

PB-ABS-461

Agency for International Development

PROJECT PAPER

**CAMEROON NATIONAL FAMILY HEALTH PROJECT
(NFHP)**

Unclassified

USAID/Cameroon

Amount Authorized: \$8,050,000

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Glossary

A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
CA	Cooperating Agency
CAA	Caisse Antonone D'Amortissement
CAMNAFAW	Cameroon National Association for Family Welfare
CBR	Crude Birth Rate
CDR	Crude Death Rate
CDSS	Country Development Strategy Statement
CHW	Community Health Worker
CMR	Child Mortality Rate
CPR	Contraceptive Prevalence Rate
CSM	Condom Social Marketing Program in Cameroon
CS	Child Survival
CUSS	Cameroon University Center for Health Sciences
CYP	Couple Years of Protection, measure of contraceptive use
DFA	Development Fund for Africa
DFMH	Directorate of Family and Mental Health
DHS	Demographic and Health Surveys (S&T/POP Project)
DPRM	Directorate of Preventive and Rural Medicine
EAPRI	Office of Economic Analysis and Policy Reform Implementation
EEC	European Economic Community
EHRD	Office of Education and Human Resources Development, USAID/C
FEMEC	Cameroon Federation of Protestant Hospitals
FHI-II	Family Health Initiatives-II (USAID/C Project)
FPIA	Family Planning International Assistance
FPLM	Family Planning Logistics Management (S&T/POP Project)
FSSRP	Fertilizer Sub-Sector Reform Program
GDP	Gross Domestic Product
GRC	Government of the Republic of Cameroon
GTZ	German Cooperation
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HPNO	Health Population Nutrition Officer
IEC	Information, Education and Communications
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INTRAH	Program for International Training in Health (contractor under PAC-II Project)
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics (S&T/POP Project)
JSI	John Snow Incorporated, contractor for SEATS Project
MCH	Maternal Child Health
MCH/CS	Maternal Child Health/Child Survival (USAID/C Project)
MOPH	Ministry of Public Health
MWRA	Married Women of Reproductive Age
NGO	Non-Governmental Organization

NPA	Non-Project Assistance
OR	Operations Research
ORT	Oral Rehydration Therapy
PACD	Project Activity Completion Date
PAC-II	Training for Paramedical, Auxiliary and Community Health Workers-II (S&T/POP Project)
PAIP	Program Assistance Identification Proposal
PCS	Population Communications Services (S&T/POP Project)
PGA	Program Grant Agreement
PHC	Primary Health Care
PHD	Provincial Health Delegate
PID	Project Identification Document
PIL	Project Implementation Letter
PMI	Maternal and Child Health Center
POPTECH	Population Technical Assistance (S&T/POP Project)
PP	Project Paper
PRAMS	Program for the Reform of the Agricultural Marketing Sector
PRB	Population Reference Bureau
PREPS	Program for the Reform of Export Marketing Sector
PSC	Personal Services Contract
PSI	Population Services International
PVO	Private and Voluntary Organization
SAP	Structural Adjustment Program
SDA	Social Dimensions of Adjustment
S&T/POP	Office of Population, AID/W
SEATS	Family Planning Services Expansion and Technical Support (S&T/POP Project)
STD	Sexually Transmitted Diseases
TA	Technical Assistance
TAACS	Technical Advisor in AIDS and Child Survival (AID/W Project)
TFR	Total Fertility Rate
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development (mission)
WHO	World Health Organization

100 ABTS 1161

Project Data Sheet

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: **A** (A = Add, C = Change, D = Delete) Amendment Number: _____ DOCUMENT CODE: **3**

COUNTRY/ENTITY: **CAMEROON**

BUREAU/OFFICE: _____

AFR/CCWA: **06**

3. PROJECT NUMBER: **631-0034**

5. PROJECT TITLE (maximum 40 characters): **Family Health Project**

PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY **12 31 96**

7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4)

A. Initial FY **94** B. Quarter **3** C. Final FY **95**

3. COSTS (\$000 OR EQUIVALENT \$) =

A. FUNDING SOURCE	FIRST FY 94			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AD Appropriated Total (Grant)	484	1,600	2,150	4,781	3,269	8,050
(Loan)						
Other: 1. U.S.						
Host Country						
Other Donors:						
TOTALS	484	2,293	2,777	4,781	3,400	8,187

9. SCHEDULE OF AID FUNDING (\$000)

APPROPRIATION/PURPOSE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
1) DFA					2,150			
2)								
3)								
4)								
TOTALS					2,150			2,150

0. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

1. SECONDARY PURPOSE CODE

2. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

B. Amount

3. PROJECT PURPOSE (maximum 480 characters)

To integrate quality child spacing and maternal health services into the national primary health care program in four provinces and to expand the availability of these services through religious, para-statal and private for-profit sector facilities.

4. SCHEDULED EVALUATIONS

Interim MM YY **01 94** Final MM YY **01 96**

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify) **935**

7. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

USAID Controller approval of methods of implementation and financing: Controller (Acting) Donald Shannon: *Donald Shannon*

17. APPROVED BY

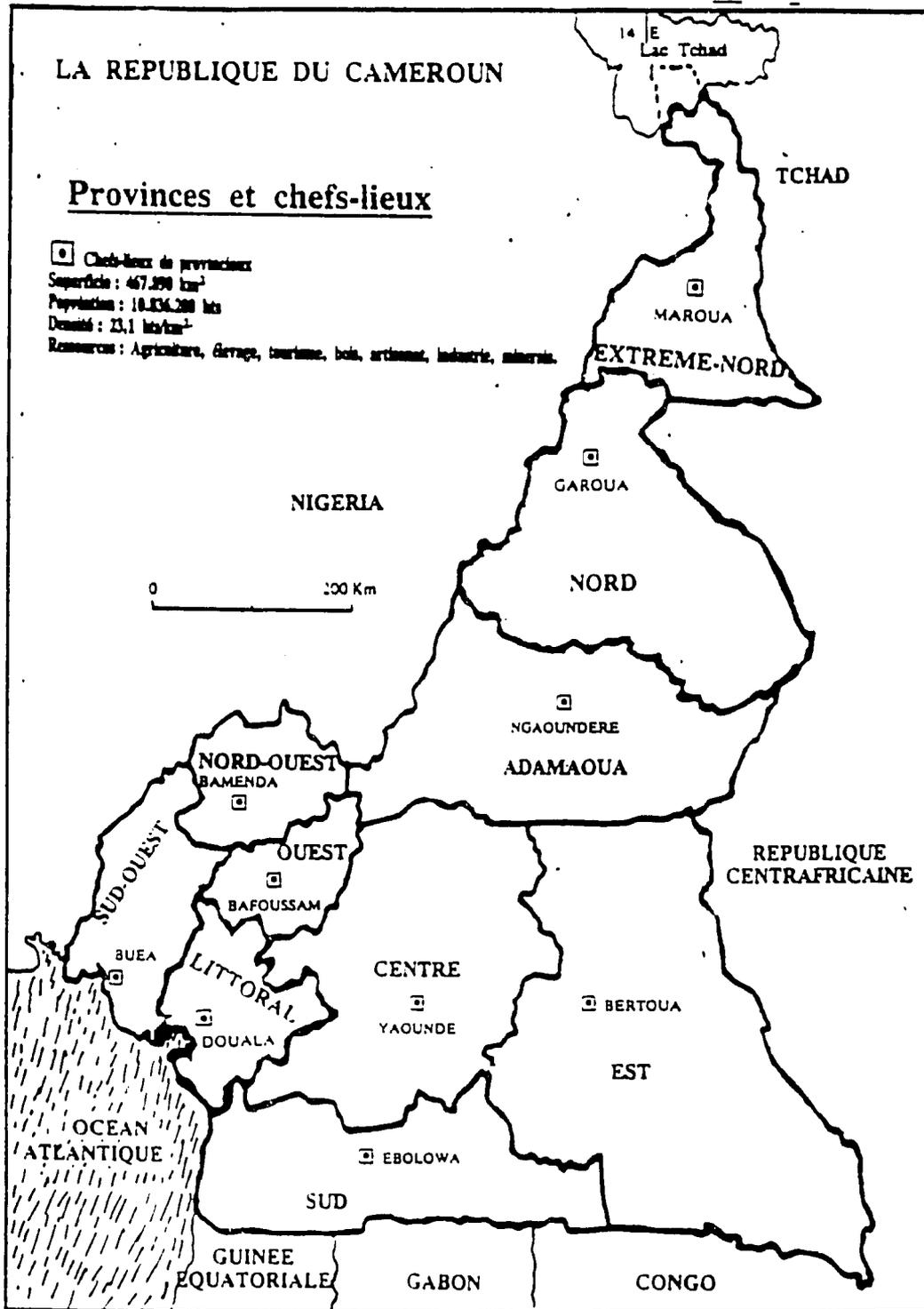
Signature: *Donald Shannon*

Title: **Director, USAID/Cameroon**

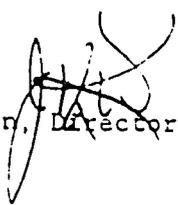
Date Signed: MM DD YY **01 21 91**

18. DATE DOCUMENT RECEIVED IN AID/W. OR FOR AID/W DOCUMENTS. DATE OF DISTRIBUTION: MM DD YY

Map of Cameroon



Action Memorandum


FROM: James Washington, Director, Office of Education and Human Resources Development

SUBJECT: National Family Health Project (631-0084)

ACTION: Your approval is requested to authorize a grant of \$8,050,000 from the Development Fund for Africa (DFA) foreign assistance appropriations account to the Government of the Republic of Cameroon (GRC) for the National Family Health Project (631-0084). The planned obligation for FY 1991 is \$2,150,000.

DISCUSSION:

A. Program Description: The National Family Health Project (NFHP) is designed to increase the demand for and the use of child spacing and selected maternal health interventions through expanding the public and private sector capacity for providing child spacing/maternal health services, supplies, and information. The program is consistent with the GRC's national primary health care program and supports its national population policy which is expected to be promulgated in late 1991. The NFHP provides funds to expand child spacing/maternal health services in the public sector; in religious, para-statal and for-profit health clinics; and in the national condom social marketing program. The project will be implemented through buy-ins to four centrally-funded cooperating agencies and through USAID procurement of contraceptives and other commodities. The GRC implementing agency will be the Ministry of Public Health, specifically its Directorate of Family and Mental Health. The field element of the project's policy reform component will be implemented by an American private voluntary organization. The NFHP will be implemented over five years and will cost a total of \$11,197,500, including the \$8,050,000 USAID contribution and a GRC contribution of \$3,137,500.

B. Conformance with A.I.D. Country Strategy: The NFHP conforms to the Development Fund for Africa Action Plan for FY 1989-1991 and USAID's 1990-1994 CDSS, its 1990-1992 Action Plan and its 1990 Assessment of Program Impact especially the strategic objective of increasing the efficiency with which public services are provided.

C. Program Beneficiaries: About 1,135,000 women and 1,300,000 children who will have access to services strengthened and provided under this project will be direct beneficiaries. Women will benefit from maternal health services, including pre and post-natal care for children, control of sexually transmitted diseases and efforts to assist with reduction in infertility. The improved health of mothers and children will lead to greater female productivity and an improved societal standards of living. Additional beneficiaries are the project's trainees themselves, largely women, who will receive technical, management and clinical training to improve their delivery of child spacing/maternal health services. The MOPH and private sector institutions will benefit from increased financial, commodity and technical support for expansion of PHC services.

D. Financial Summary: Total program funding is \$11,187,500, consisting of \$8,050,000 proposed A.I.D. life of project funding and GRC in-kind contributions of \$3,137,000.

USAID CONTRIBUTION (\$ 000)

	<u>FX Costs</u>	<u>LC Costs</u>
1. Buy-in (SEATS)	\$ 228	\$1,347
2. Buy-in (PAC-II)	\$ 158	\$1,186
3. Buy-in (JHPIEGO)	\$ 69	\$ 228
4. Buy-in (JHU/PCS)	\$ 159	\$ 341
5. Direct A.I.D.		
Procurement		
a. Contraceptives	\$2,038	
b. Other Drugs & Equipment	\$ 611	
c. Vehicle	\$ 46	
d. Evaluations	\$ 202	
e. PSC	\$ 337	
6. Reform component	\$ 250	\$ 250
7. Inflation/Contingency	\$ 600	
 TOTAL USAID COSTS	 \$4,698	 \$3,352

HOST COUNTRY CONTRIBUTION \$3,137,500 (equivalent)

E. Program Feasibility: Various analyses conducted during the design of the NFHP concluded that the project approach was technically and institutionally feasible, appropriate and responsive to the socio-cultural context of Cameroon and GRC policies, and financially sustainable. Cost benefit analyses of family planning programs in developing countries around the world show an extremely high internal rate of return. No specific cost benefit study was conducted for the design of this project.

F. Environmental Feasibility: An Initial Environmental Examination which was submitted as part of the approved Project Identification Document recommended a categorical exclusion for the project.

G. A.I.D./W PID Review Issues: All issues raised during the A.I.D./Washington PID review are addressed. There are no outstanding issues.

H. Committee Review and Recommendation: The USAID Project Review Committee was composed of representatives of the Program Office, Project Development Office, Office of Education and Human Resources Development, Controller's Office, Contracting Office, and the Deputy Director. The Committee met on July 11, 1991 to review the Project Paper and recommended that you authorize the project.

I. Congressional Notification: A Congressional Notification for the NFHP, including a LOP of \$8,050,000, was submitted to Congress on June 24, 1991 and expired without objection on

J. Human Rights: There are no human rights issues associated with the implementation of the NFHP.

K. Cognizant Project Officer: The USAID/Cameroon direct hire Health, Population and Nutrition Officer is responsible for the management of the NFHP.

M. Conditions Precedent: There are two major conditions precedent for the release of funds under the Reform Component of the project:

1. Official adoption of PHC strategy as MOPH policy. To achieve this reform the MOPH will promulgate an "arrete ministerial" signed by the Minister of Public Health declaring as official national health policy the reorientation of PHC based upon the elements of community co-management; community co-financing; availability of essential drugs; and integrated service delivery. Following signature by the Minister and distribution of the "arrete" throughout the health system, USAID will make available \$300,000 to help launch PHC activities in approximately six sub-divisions in the country. The funds will be used to purchase essential drugs, other commodities for health clinics, and in-country training of health personnel and community managers.

2. Development and adoption of service delivery and medical standards for maternal health and family planning activities. To achieve this reform the MOPH will issue a "note de service" signed by the Minister of Public Health that clearly defines the service delivery policy and medical standards required for the integration of maternal health and family planning activities into the PHC program. Following signature and promulgation of this "note", USAID will make available \$200,000 to help launch PHC activities in approximately four sub-divisions in the country. The funds will be used for the same purposes as described in reform 1 above.

Recommendation:

That you sign the attached Project Authorization and thereby authorize the proposed project at a level of \$8,050,000 over the five year life of the project:

Approved: Jay R. Shivers

Disapproved: _____

Date: 23 Aug. 1991

Attachments

Project Authorization
Project Paper
Annexes

CLEARANCES:

EHRD/HNP: RGREENE R Greene
EHRD: JWASHINGTON WAS 7/24/91
PRM: LTAYLOR 22 Aug 91
PDE: RSHOEMAKER 3/23/91
A/CONT: DSHANNON DA 7/29/91
RCO: CBENNETT CB 7/24/91
DDIR: EAMUNDSON EA 7/29/91
EHRD: GVishio GV 7/26/91
EHRD: RNana Rana 7/23/91

Draft Project Authorization

Name of Country: The Government of the Republic of Cameroon
Name of Project: National Family Health Project
Project Number: 631-0084

1. Pursuant to the Foreign Assistance Act of 1961, as amended, and the provisions of the appropriations heading, Sub-Saharan Africa, Development Assistance, contained in the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1991, I hereby authorize the National Family Health Project for Cameroon (the "Cooperating Country"), involving planned obligations not to exceed \$8,050,000 in grant funds over a five year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. Except as A.I.D. may otherwise agree in writing, the planned life of the project is five years from the date of initial obligation.

2. The project will assist the Cooperating Country to increase the use of and the demand for child spacing and maternal health services by expanding the capacity of health clinics in both the public and private sectors to provide child spacing and maternal health information and services. The project will finance technical assistance, training, contraceptives and other commodities, research, development and distribution of client information and provider training materials, evaluations, and financial management reviews.

3. The Project Agreement which may be negotiated and executed by the officers to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

a. Source and Origin of Commodities, Nationality of Supplies

(1) Commodities financed by A.I.D. under the project shall have their source and origin in countries included in A.I.D. Geographic Code 935, except as A.I.D. may otherwise agree in writing.

(2) The suppliers of commodities or services, including ocean shipping, financed by A.I.D. under the Project shall have countries included in A.I.D. Geographic Code 935 as their place of nationality, except as A.I.D. may otherwise agree in writing.

b. Conditions Precedent to Disbursement

Prior to the first disbursement under the grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D.:

(1) A statement of the names and titles of the persons who will act as representatives of the Grantee under the agreement together with a specimen signature of each person named in such statement.

(2) Evidence that the grantee has constituted a project technical committee comprised of members drawn from the Directorate of Preventative Medicine, the Directorate of Family and Mental Health, the University Center of Health Sciences, and other appropriate offices.

c. Disbursement for Policy Reform Component

Prior to the the disbursement of funds under the policy reform component of the project, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the grantee will provide, in form and substance satisfactory to A.I.D., evidence that the following actions have been completed:

(1) Promulgation of an "arrete ministeriel" signed by the Ministry of Public Health declaring the reorientation of primary health care based upon the principles of community co-management, community co-financing, the availability of essential drugs, and integrated service delivery as official national health policy.

(2) Adoption of a "note de service" by the Minister of Public Health that clearly defines the service delivery policy and medical standards required for the integration of child spacing/maternal health activities into the primary health care program.

Approved _____

Disapproved _____

Date: 23 Oct 1974

Jay P. Johnson
Mission Director
USAID/Cameroon

Clearance: As shown on the Action Memorandum

1. Introduction

A. Macro-economic Environment

The Republic of Cameroon experienced relatively rapid economic growth throughout the 1970s and into the mid 1980s. Growth was led by export earnings from agricultural products, principally coffee and cocoa. During this period, the gross domestic product (GDP) increased at an average annual rate of 5.2 percent from 320 billion FCFA francs in 1970/1971 to 1,800 billion FCFA francs in 1980/1981. The substantial expansion of oil production beginning in 1978 further accelerated the growth of the GDP to 9 percent annually from 1980/1981 to 1985/1986, with per capita income reaching the equivalent of \$800.

Since 1986, Cameroon has endured an economic recession which has resulted in an estimated 21 percent decline in the GDP. The drop in the world price of oil in 1986, and the subsequent steep reduction in the world prices of cocoa and coffee, beginning in 1987 and continuing up to the present, have cut export earnings by almost one-third. This drastic reduction in export earnings has plunged Cameroon's economy into the recession and financial crisis which the country is still struggling to overcome.

According to USAID's Cameroon Action Plan 1990-1992, "there is little cause for optimism regarding the Cameroonian development environment. This environment is an extremely difficult one in which maintaining zero growth should be viewed as a very significant accomplishment." Indeed, since the Action Plan was written there has been further economic decline.

Cameroonian Approach to Structural Adjustment of the Economy

Beginning in early 1988, the GRC began discussions with both the International Monetary Fund (IMF) and the World Bank regarding the stabilization and structural adjustment of its economy. With the support of a Stand-By Agreement approved in September 1988 and a Structural Adjustment Loan approved in July 1989, the GRC began to undertake actions aimed at 1) curtailing the growth of public expenditures; 2) strengthening and broadening revenue collection; 3) reforming the civil service; 4) liberalizing the trade regime; 5) liquidating, privatizing, and restructuring the parastatal sector; and 6) restructuring the commercial banking sector.

USAID Support for Structural Adjustment Program

During the period of sustained economic crisis, USAID/Cameroon has focused its program to support the ongoing structural adjustment program (SAP) that is being pursued jointly by the GRC and the major donors. The mission's approach emphasizes addressing the dysfunctional institutional arrangements that underlie existing economic problems. It is the mission's view that the set of formal and informal rules, regulations, and incentives that have been developed since independence to support a state-led model of development must be replaced with a new set of institutional arrangements that will support private sector activity and investment. The present USAID program in support of structural adjustment includes the Policy Reform in the Export Processing Sector Program which supports the development and implementation of a privately managed Free Trade Zone Regime; the Program of Reform in the Agricultural Marketing Sector which aims to remove the marketing impediments and pricing constraints in the arabica coffee subsector; and the Fertilizer

Subsector Reform Program which aims to eliminate the subsidy on fertilizer and to privatize the marketing of fertilizer.

Social Dimensions of the Structural Adjustment Program

The current economic crisis has led to a significant reduction in per capita income and the private consumption of goods and services during the last three years. In addition, in its effort to reduce significantly the public budget deficit, the GRC has curtailed grants to the social sector including such fundamental domains as health and education. The economic downturn and the resulting structural adjustment program has also had an overall negative impact on employment. In response, the GRC, in collaboration with multilateral and bilateral donors, developed the Social Dimensions of Adjustment (SDA) Program. The principal objectives of this program include

- protection of the disfavored and vulnerable segments of the population, particularly groups directly affected in the short and medium term by the economic crisis and the adjustment program;
- greater participation of poor groups of the population in the process of recovery; and
- direct assistance to the health sector.

The SDA Program has been an effective mechanism to mobilize donor funding in the areas of health, population, education, employment, and women in development. Major donors in the health sector include the European Economic Community (EEC), the French Government, the German Technical Cooperation (GTZ), the Japanese Government, the United Nations Fund For Population Activities (UNFPA), USAID, the Belgian Government, UNICEF, the Swiss Government, and the World Health Organization (WHO). The health assistance programs of USAID, GTZ, the Belgians, and UNICEF are focused on supporting primary health care. The EEC has developed plans to restructure the pharmaceutical sector. The French Government has concentrated its resources in tertiary and curative care. The World Bank is presently planning to fund a Program Preparation Fund Project which will finance studies in the health sector as a preliminary step to an eventual health sector loan. WHO, UNDP, USAID, GTZ, and EEC are the major donors of Cameroon's Medium-Term AIDS Program. Finally, USAID and UNFPA are the chief donors involved in supporting the delivery of family planning information and services.

B. Health Sector Environment

Cameroon's ongoing economic recession has affected social services, particularly the delivery of public health services. The Ministry of Public Health (MOPH) budget has registered a sharp decline since 1986, dropping from a high of 26.75 billion FCFA in 1986/87 to 22.76 billion FCFA in 1990/91. Prior to the economic crisis, in excess of 30 percent of the health budget was allocated to the rural health services (arrondissement-level hospitals, health centers, and village health posts). In 1988, because of the worsening economic crisis, the budget for rural health care was cut by 50 percent causing an almost complete cessation of support and supervisory services. The supply of medications to rural facilities, already inadequate, virtually ceased. These financial problems, which have continued, are exacerbated by inefficient health budgeting, planning, and resource allocation practices. Furthermore, MOPH personnel, faced with limited resources to perform their jobs properly and serious problems of accountability and lack of incentives, are poorly motivated and have lost the confidence of the

communities they were intended to serve. Health center utilization, already low, has worsened. As a result, primary health care and the rural health services have ceased to function in a coordinated, effective fashion.

The weaknesses of the public health system are manifested in the low coverage rates for preventive services. National vaccination coverage for measles remains under 40 percent and less than 25 percent of the nation's children are completely vaccinated. Oral rehydration therapy (ORT) usage rate is estimated at 24 percent. Despite 100-150 private pharmacies in the country selling contraceptives, contraceptive prevalence is estimated at 2 percent and child spacing services are available in less than 30 public clinics. Although the infant and under five mortality rates have declined to approximately 90 deaths per 1000 live births and 150 deaths per 1000 children under age five respectively, these rates appear to be levelling off rather than declining.

Constraints within the Health System

Resource Allocation. There is excessive concentration of budgetary resources on wages as opposed to non-wage recurrent costs and investment costs. Wages consume approximately 80 percent of the recurrent cost budget and 70-75 percent of the total health budget. Investment spending in health now represents no more than 1 percent of total GRC investment spending, much of it still allocated to hospital construction and other major capital projects.

Health Personnel System. Despite numerous medical, paramedical, and administrative personnel, the professional health cadre is lacking in motivation due to inappropriate incentives, the limited means available to treat patients, and poor relations with the community. In addition, personnel are maldistributed in favor of the urban areas and they lack clear job descriptions. The problems in the civil service personnel system (lack of accountability, insufficient career development, supervision, and in-service training) have resulted in poor morale among all cadres of health professionals.

Rural Health Services. Despite adequate numbers of personnel and a fairly well developed infrastructure, the rural health services are hampered by the lack of availability of essential drugs, laboratory equipment and reagents, and other expendable supplies. The lack of community- managed or private pharmacies in rural areas limit the availability of pharmaceuticals to the inadequate supplies of free drugs furnished periodically by MOPH facilities. Clinical practices are characterized by the prescription of inappropriate medications (e.g., injectable quinine for malaria and anti-diarrheals rather than ORS for childhood diarrhea), over-medication, little follow-up of illnesses, and vertical organization of the various services offered at health facilities. Logistical systems work poorly and result in frequent stock-outs of drugs, vaccines, and other essential supplies such as refrigerator parts. Preventive programs such as childhood immunizations, ORT, nutrition monitoring and promotion, child spacing, and pre- and post-natal care are absent from many health centers.

Medical Referral System. The medical referral system lacks clear guidelines for identification of at-risk patients and no follow-up or feedback on referred patients. Due to a lack of confidence in primary health care centers, patients often bypass these structures and utilize secondary and tertiary facilities as dispensaries, in the belief that these facilities are more likely to have drugs and other supplies.

Supervision. The little supervision which is conducted in the health system is hampered by the lack of supervision guidelines and protocols, little follow-up of findings, and inappropriate attitudes on the part of supervisors.

Health Information. The national health information system is non-functional due to the plethora of forms, excessive information requests, poor utilization of the results at all levels, and lack of training of personnel in information collection and recording.

Pharmaceutical Procurement. There currently exists no functioning structure designated as responsible for the procurement and provision of drugs to public health facilities. ONAPHARM, the parastatal mandated by law to fulfill this role, has not been able to procure significant quantities of drugs for the past two years and presently has a 2 billion FCFA debt. The existing primary health care (PHC) projects depend for essential drugs on a limited number of local private suppliers. These suppliers do not provide a consistent supply of pharmaceuticals and charge relatively high prices, effectively increasing the percent of the population without access to essential drugs. Although a national essential drugs list is in circulation, it has not been officially authorized. The result is continued procurement and use of non-essential drugs by MOPH staff, increasing costs and often leading to inappropriate treatment of clients.

Public/Private Sector Coordination. The Cameroon health sector includes religious hospitals and clinics, employee-based health facilities, and for-profit clinics and hospitals in large urban areas. However, despite the severe financial constraints facing the sector, little attention is focussed on the integration of these resources. As a result, there is duplication of services (religious and public health facilities next to each other), no consistent medical standards and procedures in the sector, and no plan to address effectively under-served areas with available resources from the public and private sectors.

Financial Administration. All MOPH resource allocations are made based on a cumbersome credit system. Because of the financial crisis and the government's inability to pay its bills, private suppliers often refuse to accept MOPH purchase orders. In addition, some provincial treasuries are chronically short of cash and cannot provide payments in support of any government service. The result is that many of the MOPH's allocations cannot be utilized. In addition, the MOPH's budget is burdened by salary payments to persons not active in the workforce.

Health Planning. The MOPH produces annual health plans and is in the process of developing a national health plan for the country. However, health planning exercises to date have been hampered by too many objectives, no prioritization of activities, no linkage of activities with available resources, and little monitoring and evaluation of plans. In addition, there is little health planning at the provincial, divisional, and sub-divisional areas.

C. Background Information on the Health Sector

Health-Population Profile

Since 1950, dramatic improvements have occurred in the health status of the Cameroonian population. The crude death rate has declined from 27 deaths per 1000 population to 14/1000 according to the 1987 National Population Census. During the same period, life expectancy at birth has risen from 35 to 54 years. Infant mortality has similarly declined from 170 deaths per 1,000 live births to approximately 90/1,000 and child mortality from over 250 deaths per 1,000 children under age five to approximately 150/1,000. At the same time, fertility and population growth rates have increased with the latter rising from approximately 1.5 percent to the present annual growth rate of 2.9 percent. The 1978 National Fertility Survey measured a contraceptive prevalence rate of 2

percent, which by all estimates has not significantly changed since that time. The crude birth rate is estimated to be between 42 and 45 births per 1,000 population, a high rate even by African standards. At current fertility rates, the average Cameroonian woman can expect to have six living children during her reproductive years.

Despite important declines in child and infant mortality rates over the past 40 years, evidence indicates that infant and under five mortality rates are reaching a plateau (the annual rate of decrease being almost halved from that of the previous decade). In addition, present infant and child mortality rates are comparable to those in African countries that are much less developed than Cameroon.

Morbidity and mortality among infants and children in Cameroon are largely preventable and generally caused by illnesses whose early diagnosis and treatment could substantially reduce mortality. The most important among these are malaria, measles, tetanus, diarrhea, pneumonia, meningitis, and malnutrition. According to a study conducted in Cameroonian health centers in 1986 (cited in Analyse de la Situation Des Enfants et Des Femmes en Republique de Cameroon, UNICEF, 1990), the principal causes of reported infant (0-11 months) mortality at health centers in 1986 were as follows:

<u>Disease</u>	<u>Number of Deaths</u>	<u>Percent</u>
Tetanus	208	19.3
Pneumonia	191	17.7
Malaria	155	13.2
Diarrhea	139	12.9
Meningitis	106	9.8
Malnutrition	75	6.9
Others	<u>64</u>	<u>5.9</u>
Total	1081	100%

Regarding morbidity and mortality among adults, the principle causes include malaria, respiratory diseases, diarrhea, tuberculosis, schistosomiasis, and sexually transmitted diseases (STDs), including AIDS. The national prevalence of the human immunodeficiency virus (HIV) infection in the adult population is estimated at one percent and is increasing slowly but steadily.

The principle maternal health problems in Cameroon include STDs, anemia, tuberculosis, and HIV infection. High rates of STDs have contributed to significant rates of infertility.

Structure of the Health Service Delivery System

Ministry of Public Health. The MOPH is composed of a private secretariat to the Minister, an Office of the Inspector General, two Technical Advisors, a Central Administration, and External Services. The Central Administration consists of the following six directorates: Hospital Services; Preventive and Rural Medicine (DPRM); Family and Maternal Health (DFMH); Pharmacy; Planning, Studies, Statistics; and Administrative Affairs. All directorates report to the Secretary General who heads the Central Administration. The Inspector General and the two Technical Advisors receive instructions directly from the Minister.

The External Services of the MOPH comprise the following:

- Provincial Delegations of Public Health
- Divisional Services of Public Health
- Sub-divisional Services of Public Health
- Health Facilities and Special Services

The Provincial Delegations of Public Health are headed by Provincial Health Delegates (PHDs) who are the representatives of the Minister in their respective provinces. As such the PHD is the chief medical officer in charge of overseeing all provincial level public health services -- delivery of curative care, administration, health planning, and preventive medicine activities and programs. Reporting directly to the PHD are the Provincial Chief of Preventive Medicine and Public Hygiene (overseeing preventive medicine activities) and the Provincial Chief Medical Officer, who is the director of the provincial hospital.

At the divisional level, the representative of the Minister of Public Health is the Divisional Chief Medical Officer, who is also responsible for managing the divisional hospital and supervising the medical staff of sub-divisional hospitals. Overseeing all preventive activities in the division, as well as the health centers and health posts, is the Divisional Chief of Preventive and Rural Medicine. Both officers report directly to the Provincial Health Delegate.

At the sub-divisional level, the representative of the Minister of Public Health is the Medical Officer in charge of the sub-divisional hospital, which serves as the referral point for PHC activities at that level. At the provincial, divisional, and sub-divisional levels there are Primary Health Care Coordinators who supervise the village health posts staffed by community health workers.

Tertiary Care. Tertiary care is carried out in four large referral hospitals located in Yaounde and Douala. A full service hospital offering specialty care is located in each of the provincial capitals. General hospitals which do not offer specialty services are located in the divisional and sub-divisional capitals. Sub-divisional hospitals (one is located in each sub-divisional capital) frequently resemble well equipped health centers.

Primary Health Care. Primary health care is delivered through a network of health centers and village health posts. Health centers are defined as either elementary (defined to serve approximately 5,000 people) or developed (serving 10,000 people and including some maternity and in-patient beds). In practice there is little distinction between the two types of facilities. The best estimate of the number of functioning public health centers in the country is between 600-800. For village health posts, communities contribute resources and build health units out of local materials. Community health workers (CHWs) are selected by the village and trained at the sub-divisional hospital. The community is responsible for the remuneration of CHWs. The government considers the health posts to be outside of the public sector.

Other Facilities. There are approximately 59 maternal/child health centers in the country, many of which are attached to provincial hospitals. In addition there are approximately 23 women's centers managed by the Ministry of Social and Women's Affairs which conduct income generation, counseling, and health programs targeted at women. Finally, Cameroon has approximately 100 pro-pharmacies, which are MOPH recognized community-owned drug stores in areas where there are no commercial outlets.

Private Health Sector. There are currently operating in Cameroon some 25 to 35 Protestant hospitals, 15 to 20 Catholic hospitals, and hundreds of health centers, small satellite dispensaries, and mobile clinics which are supported by these hospitals.

In addition, there are 30 to 50 private and parastatal businesses which manage their own health facilities for their employees. There are also an undetermined but large number of private for-profit clinics and several hospitals in the cities and towns of the country. Finally, there are approximately 200 private pharmacies operating in Cameroon.

Family Planning in Cameroon

Cameroon is gradually moving from a pro-natalist stance to one in which population issues are discussed openly and family planning services are being provided. Within the last two years, the government has taken significant actions to institutionalize family planning services. In 1989, the MOPH created the Directorate for Family and Mental Health which has a mandate to promote child spacing as an integrated element of the maternal and child health programs. Supported by this directorate, family planning services are currently offered at approximately 30 public sector health facilities, approximately 10 Protestant health facilities, and in a handful of parastatal and private for-profit health centers. In addition, clinical training sessions are being organized and seminars on reproductive health issues are being conducted. With a current birth rate of 42-45 births per 1,000 population, Cameroon ranks among those countries with the highest birth rates in the world. At the current population growth rate, the population of Cameroon will double in 23 years.

In 1989, the GRC, in response to the economic crisis and the 2.9 percent population growth rate in the country, completed a draft national population policy. This policy, which is expected to be authorized in late 1991, provides a clear strategy to define the population component of the SDA program. The draft policy calls for the development of integrated child spacing information and services in both the public and private sectors in order to reduce the prevailing high infant, child, and maternal mortality rates, improve the health status of women and children, and decrease the prevailing high demographic growth rates in the country. The GRC is now attempting to mobilize donor support to provide access to child spacing information and services to both urban and rural populations.

Information regarding the demand for family planning methods is not well represented by the number of new acceptors at the few facilities in Cameroon currently offering family planning services. As would be expected, the demand for family planning services currently differs between urban and rural areas. For the country as a whole, it is estimated that contraceptive prevalence is about 2 to 3 percent of all women between the ages of 15 and 49. Data from the 1978 Cameroon Fertility Survey showed that only 29 percent of women knew of a modern contraceptive method; however, 75 percent of respondents expressed a desire for more information about ways to plan their families. More recent research by JHU/PCS suggests that the demand for family planning information and services is higher now than in 1978. Just as views of government regarding family planning have changed, so too are the preferences of a population which is rapidly urbanizing. Contraceptive practice is expected to increase considerably once trained personnel and equipped facilities are available for the provision of services.

Economic Analysis of the Health Sector

Cameroon is considered to be a lower middle income country based upon a per capita income of \$800 (1987 estimate). Unfortunately, Cameroon's health indicators (for example, infant mortality rate of about 90/1000 with much higher rates in some regions of the country) are more indicative of lower income countries. This poor performance in the health sector has prevailed despite relatively high public expenditure levels for health (\$12.60 per capita in 1988/89).

Although GRC budgetary allocations for health grew during the 1970s and the early 1980s, they did not grow as fast as overall government spending. As a result, the percentage of the national budget devoted to health has fallen from approximately 6 percent in 1968/1969 to a current level of only 4.1 percent for the 1990/1991 budget. This is well below WHO's recommendation that lower income countries devote 10 percent of their national budgets to the health sector. The GRC budget allocations for health as a percent of the overall GRC budget have fallen steadily in recent years and the current economic crisis has necessitated a drop in overall government spending. As a result, the GRC recurrent health budget has dropped from 27.8 billion FCFA in 1986/1987 to its present level of 22.75 billion FCFA. Table 1 summarizes recent trends in the GRC recurrent health budget.

Table 1
Recurrent Health Budget, Cameroon 1983-1991

Year	National Budget	Health Budget (Billions FCFA)	% Health (Billions FCFA)
83/84	520	22.89	4.4
84/85	620	23.02	3.6
85/86	740	26.75	3.6
86/87	800	27.81	3.5
87/88	720	25.62	3.6
88/89	600	23.98	4.0
89/90	600	25.87	4.3
90/91	550	22.76	4.1
91/92	545	24.36	4.5

The GRC investment budget for health totaled a mere 2.6 billion FCFA during the period between 1981 and 1985. Investment spending increased markedly in 1986 to a total of 23 billion FCFA and remained at similar levels for several years (21.5 billion FCFA in 1987/1988 and 17.6 billion FCFA in 1988/1989). Most of this investment spending was consumed by hospital construction. In 1987/1988 only 14 percent of investment was spent for the construction of primary health centers. Hospital construction grew to 92 percent of health investment spending in 1988/1989. Indications are that investment spending for health has fallen drastically in the 1989/1990 and 1990/1991 budgets and represents no more than 1 percent of total GRC investment spending.

Within the GRC recurrent health budget, personnel costs currently consume over 80 percent of the total. This leaves little for drugs and other operating costs. In 1989/1990, 2.1 billion FCFA (93 FCFA per person) was allocated for drugs within the total recurrent health budget. In the same year, GRC expenditures for drugs amounted to only 400 million FCFA (19 percent of budget) or a mere

37 FCFA per person. With high fixed personnel costs, there appears little hope for improvement in this situation.

There exists a significant private sector for health care delivery in Cameroon. This sector is composed of both private for-profit practitioners and pharmacies and non-profit facilities operated by religious and private voluntary organizations. There is no information available regarding total expenditures within the private sector (although one source estimates that non-profit sector spending represented approximately \$15 million in 1986). However, it is estimated that in 1989 a total of 28 billion FCFA was spent on drugs through the private for-profit sector and another 1.8 billion FCFA by the non-profit sector (the 400 million FCFA spent on drugs by the MOPH represents, therefore, a mere 1.3 percent of spending on drugs in the country).

Despite the former MOPH policy of free health care (including drugs) for all, it is clear that households have traditionally spent significant amounts on health care. A 1983 study estimated that spending on health care was approximately 15,000 FCFA per person per year nationwide. This figure represents a national average based upon estimates of 21,120 FCFA per person per year for urban populations and 4,587 per person per year for populations living in rural areas with limited access to health care. Other studies of demand for health care and current household expenditures for care are under way in conjunction with the USAID Maternal Child Health/Child Survival Project.

Under its new policy to introduce cost recovery in the health system, the MOPH has allowed hospitals to begin to collect fees for services. In addition, recent legislation has been approved allowing health facilities to charge patients for drugs. The MOPH, with USAID assistance, is planning in 1991 a study of the fees charged and the revenues generated at one hospital in Douala. Operations research on the ability of health centers to recover recurrent costs beyond drug sales is currently being conducted in collaboration with donor (including USAID) assisted projects in several provinces. Such research will provide the MOPH with further information to modify the health finance policy in the future.

D. Description of PHC Sub-Sector: The MOPH's Response to Constraints in the Health System

The MOPH has confronted the identified problems of the national health care system by attempting to improve primary health care -- the most basic level of health services. In 1989, the MOPH conducted a national assessment of the existing PHC program and developed a revised PHC strategy. This strategy, which is described below, stresses community involvement in PHC, community co-management of health facilities, community co-financing of health services, and full integration of interventions. USAID was the first donor to provide full support for this new strategy under the Maternal Child Health/Child Survival (MCH/CS) Project. Other health donors, including the German Cooperation, UNICEF, French Cooperation, the EEC, the Swiss Cooperation and the Belgian AID, have also embraced the MOPH's new PHC strategy in their rural health care programs. The MOPH has now identified donors to fund the revised PHC strategy in major areas in all 10 provinces. USAID's entire health and population portfolio is now oriented to this new approach.

Description of the MOPH's New PHC Strategy

In May 1989, the MOPH released its new PHC strategy in a document entitled Reorientation of Primary Health Care in Cameroon. This strategy follows closely both UNICEF's Bamako Initiative

and WHO's strategy of delivering primary health care in three phases. The plan conforms to the administrative division of the country into provinces, divisions, and sub-divisions.

According to the new strategy, the national health system will be reorganized in such a way that local communities will take greater responsibility for their health care. Each political sub-division in the country will be organized as a health district which will receive technical and administrative support from the divisional and provincial levels. Within the health district, health areas will be established in zones surrounding functional health areas. Health centers will be co-managed by the community health committee of the health area. Each health center will have a drug store and other cost recovery mechanisms which will permit the funding of certain recurrent costs of the PHC program. The community health committee will manage the funds generated from the cost recovery mechanisms. Health services will be delivered in a fully integrated fashion with emphasis on continuity of care for each episode of illness. A full description of the PHC system is outlined below.

Community/Village Level. The existing village health posts, community health workers, and village health committees will be maintained.

Health Center Level (Health Area) (population 3,000-15,000). A community health committee will be elected to represent the concerns of all the villages in the health center's catchment area. The health committee will select a subcommittee responsible for managing the health center and pharmacy. This management subcommittee will consist of community representatives and health center personnel, and will be overseen by the chief medical officer of the sub-division.

The health center will be reinforced to serve as the focal point of PHC in the area. The health center will provide fully integrated services consisting of child survival interventions, antenatal consultations, treatment of acute and chronic diseases, health promotion, and collection of health information. The health centers will provide patients continuous care during each episode of illness or risk. Each health center area will be defined and mapped.

Each health center will establish a pharmacy stocked with essential drugs and other essential health supplies. These community-managed pharmacies are intended to sell drugs at low prices but to still be able to make a profit sufficient to cover many of the variable recurrent costs of the health center. Fees for consultation, pre-natal care, care of children under age five, wound dressings, and deliveries will also be charged at health centers.

Sub-Divisional Level. a) Each sub-division will be divided into its health centers and their catchment areas (health areas). The sub-division (health district) will be the functional management unit of the new health system. A health district team (including public health and PHC specialists) will be responsible for coordinating all PHC activities throughout the sub-division. b) The sub-divisional hospital will serve as the referral hospital for the health centers in the sub-division. c) A sub-divisional health committee will be created consisting of representatives from the different area health committees. d) The sub-divisional health committee will form a management sub-committee responsible for overseeing the sub-divisional hospital and pharmacy and the divisional drug depot, if one is located there.

Divisional Level. The divisional health team will provide technical and administrative supervision of the sub-divisions.

Provincial Level. a) The provincial health team will provide technical and administrative supervision to the divisions. b) The provincial hospital will serve as the referral hospital for the sub-divisional hospitals. c) A provincial health committee will be created consisting of representatives from the sub-divisional health committees. d) Each provincial health committee will form a management sub-committee responsible for overseeing the provincial hospital and pharmacy and the provincial drug depot.

Financing the System. The MOPH, with contributions from international donors, will provide salaries, pre-service training of health personnel, construction and rehabilitation of health centers, transport for health centers, the initial supply of drugs to be sold in the pharmacies, and other costs. The community will participate in financing its health care through

- purchase of essential drugs;
- payment for consultation and other medical services; and
- contributions from development committees of the catchment area.

The management subcommittee of the area health committee will utilize the above sources of income to finance

- the salary of a private administrative agent to manage the pharmacy and other cost recovery activities;
- the replenishment of the pharmacy;
- the reorder of different forms used by the MOPH;
- the reorder of laboratory reagents and expendable supplies;
- the costs related to mobile activities (outreach, supervision of PHC posts, etc); and
- other health-related costs as determined by the health committee.

(Note: Due to the lack of a viable national drug procurement entity, the MOPH envisions that communities will procure essential drugs from private drug suppliers.)

Supervision. Supervision will be both technical and administrative. The sub-divisional team will conduct supervision to support the health center staff, management committees, and health committees in their different management roles. Technical supervision will focus on maintaining the correct delivery of health services by medical personnel. A supervision hierarchy will ensure that all workers receive regular supervisory visits which will be supported by a program of in-service training.

Experience to Date with the Revised PHC Approach and Perceived Constraints

The MOPH's reoriented PHC strategy is intended to address many of the key constraints of the health sector including

- the lack of essential drugs and reagents (by establishing locally managed revolving fund drug stores);
- poor motivation of health personnel (by involving the community in the planning, management, and financing of health care);
- lack of supervision and outreach activities (by community financing of PHC operating costs);

- lack of a medical referral system (by establishing clear referral guidelines and training health workers in the principle of continuity of care); and
- lack of health planning at the provincial, divisional, and sub-divisional levels (by strengthening staff capabilities and developing the health management information system [HMIS]).

This reoriented strategy is being implemented in pilot zones in Adamaoua, South, Extreme North, North-West, and West Provinces with plans under way to begin implementation in major areas of the remaining provinces over the next five years. Experiences to date are positive but indicate that there exist important policy and operational constraints to the effective implementation of this program nationwide. The policy-related constraints to the new PHC strategy include the following:

- There is no official statement declaring the reorientation of PHC strategy as national health policy.
- There is no legal basis for the local management of revenues generated from the collection of fees for services at health facilities.
- The present health personnel profit sharing system does not include all operational, support, and service delivery personnel. At present, only medical doctors who conduct consultations are included in the profit sharing system. This provides no motivation for medical and paramedical personnel to conduct public health, preventive, management, and supervisory activities. In addition, the present profit sharing system provides no incentive to non-physicians to correctly apply fee structures and collect fees.
- There is a lack of an officially authorized essential drug list containing modern contraceptives.
- There is a lack of family planning/maternal health medical standards and service delivery policies.
- Health personnel are maldistributed in favor of urban areas resulting in certain health areas without sufficient health staff.
- The national drug procurement body has ceased to function effectively, resulting in no effective mechanism by which to purchase generic essential drugs in bulk for the population. The existing PHC projects are purchasing drugs from a limited number of local private suppliers plagued by high prices and occasional stockouts.
- The GRC's financial and accounting system and budgetary crisis make it very difficult for health facilities to obtain the primary health care credits allocated by the MOPH.

The major operational constraints of the reoriented PHC program are as follows:

- The purchasing power of the population has been reduced due to worsening of the economic crisis. This could have an adverse affect on the population's willingness and ability to pay for health care.
- Low population densities in certain areas prevent community-financed health centers from recovering fixed costs.

- The GRC is unable to maintain present funding levels for the MOPH due to the economic crisis. This could prevent the MOPH from making its assigned contribution to the co-financed program.
- The lack of adequate facilities and staff at certain sub-divisions make them poor locations for health districts.
- The MOPH organizational structure encourages the adoption of vertical service delivery programs and makes coordinated planning and implementation of national programs difficult.
- There is a lack of banks in rural areas. This makes it difficult for community health committees to properly safeguard and manage their funds.
- There is a lack of financing for essential drugs and equipment to launch the reorientation of PHC outside the donor-funded intervention zones.
- There is a lack of financing for renovations of health facilities in disrepair throughout the country.
- There is a lack of progress in persuading religious and other private health facilities to fully participate in the program.

Resolution of Constraints

USAID, the other donors involved in the PHC program and the MOPH have begun to address the policy and implementation constraints affecting the PHC program. Texts have been drafted concerning the official adoption of the reorientation of PHC as national health policy. This project will assist the MOPH in the timely adoption of this text. The MOPH has also completed a draft essential drug list which is now under internal review. Although the MOPH has drafted a text to legalize the local management of revenues generated from the collection of fees for service at health facilities, the acceptance of this reform by the Ministry of Finance is still not assured. USAID, the German Cooperation, the World Bank, and others will continue to use their programming leverage to assure the adoption of this reform. Once the local management of revenue is legal, the MOPH will proceed with its plans to reform the profit sharing system.

Regarding the maldistribution of health personnel and the weakness of the budgeting system, these reforms are linked to systemic changes in the GRC's public administration. As such, these reforms will need to be government-wide and included as part of the administrative reforms under the World Bank's structural adjustment program. The reform of the national drug procurement system will be addressed jointly by the major PHC donors in conjunction with the World Bank. An important study of drug procurement practices will be launched in late 1991. Finally, the reform component of this project will provide assistance in developing and officially adopting child spacing/maternal health medical standards.

Regarding the operational constraints of the PHC program, many of these issues are being addressed through the implementation of USAID's Maternal and Child Health/Child Survival (MCH/CS) project and other donors' PHC projects. The problems related to the economic crisis are not expected to be resolved in the near-term. The problem of low population densities can be ameliorated by establishing a system of provincial cross subsidies. Plans for this have already been designed. Regular

coordination meetings are now being conducted to deal with the issue of public and private sector coordination.

2. Project Rationale

A. Problem Statement

Cameroon's ongoing economic recession has adversely affected the public sector. As described in Section 1, the MOPH budget has registered a sharp decline since 1986 with funding for rural health care reduced dramatically. These funding cuts exacerbated the problems of the national health care system which include lack of medications and supplies at health facilities, lack of supervision and refresher training, no referral system or outreach activities, and poorly motivated personnel. As a result, the national health care system has ceased to function in an effective fashion. Low utilization rates at health facilities have resulted in a low level of coverage for vaccinations, ORT usage, growth monitoring, and pre- and post-natal care services. Contraceptive prevalence is estimated at 2 percent and child spacing services are available in fewer than 30 public clinics. High rates of STDs have resulted in significant infertility problems.

Accelerating population growth has exacerbated the country's economic problems. Cameroon's population has grown from 5.5 million in 1960 to an estimated 11.5 million in 1990. The population growth rate of approximately 1.5 percent in 1950 has now increased to 2.9 percent, which, if sustained, would double the population again in 23 years. The crude birth rate of about 42-45 births per 1,000 population is a high rate even among African countries. Increased population growth has placed additional stress on Cameroon's weak social services, increased unemployment, encouraged rural to urban migration, and endangered the environment. Rapid population growth and high risk births (mothers too young or too old and having too many and too frequent pregnancies) have also adversely affected maternal and child health and the MOPH's ability to improve the country's poor preventive coverage rates.

In view of the acknowledged weaknesses of the national PHC program, the MOPH, in 1989, undertook a national assessment of rural health care and developed a revised PHC strategy. This strategy, described in Section 1, stresses community involvement in PHC, community co-management of health facilities, community co-financing (with the MOPH) of health services, and full integration of interventions. The MOPH now requires support to implement this new strategy so that the weaknesses of the PHC system can be addressed and community support and financing can result in genuine improvements in health care, increased utilization of health facilities and preventive services, and improved health worker performance. USAID (through its MCH/CS project and the Reform of the Health Delivery System Projects), UNICEF, the French Cooperation, Belgian AID, and German Cooperation are assisting the MOPH to implement the policy in major areas of all 10 provinces.

To date, however, no plan has been developed to integrate child spacing and key maternal health services such as pre- and post-natal care, infertility and STD services and promotion of breastfeeding into either the MOPH's PHC program or the private health sector. This is needed in order to make child spacing and maternal health accessible to the rural population; to improve community knowledge and use of maternal health and child spacing technologies; to make these services affordable; and, ultimately, to improve maternal and child health.

B. Project Response

The National Family Health Project will address the constraints of the health sector by supporting and enhancing the MOPH's reoriented PHC program. Specifically, the project will introduce child spacing and maternal health services into community co-managed and co-financed health facilities. This will increase access to these services and improve the overall quality of preventive care provided the population. As a result of these new services, utilization of health facilities will increase which will enhance the financial viability of the PHC program. The services will be affordable and sustainable because of their integration into PHC service delivery, logistics, supervision, and information systems.

In addition, the project will assist the MOPH to resolve two critical policy constraints to the nationwide expansion of the reoriented PHC program and to the integration of child spacing and maternal health services into this program. Although this component cannot resolve all of the policy issues affecting the program, it can address two key, non-controversial reforms which are sequentially important at this stage of project implementation.

Finally, the project will improve maternal and child health by introducing maternal health and child spacing information and services into private for-profit, religious, and parapublic health facilities, and by expanding the ongoing condom social marketing program nationwide.

C. Conformance with A.I.D. Policies and Procedures

This project conforms to the Development Fund for Africa Action Plan for FY 1989-1991, Target 1.3, which calls for the integration of family planning information and services in PHC programs and emphasizes the need for cost recovery mechanisms in the health sector.

The Program Goal adopted by USAID/Cameroon in its 1990-1994 CDSS, its 1990-1992 Action Plan, and its 1990 Assessment of Program Impact Report, is to assist Cameroon in achieving sustainable, market-oriented, and broadbased economic growth. To achieve this goal, USAID has identified two strategic objectives: increasing the role and efficiency of private markets and increasing the efficiency with which public services in agricultural research, higher education, and health are provided. This project directly supports the mission's public sector strategy by integrating quality child spacing information and services into the national PHC program. In addition, the project, by supporting the MOPH's revised PHC strategy, will improve the efficiency of the health sector by fostering the decentralization of health planning, the community management of health facilities, and the community co-financing of health services. Finally, by expanding the role of private health care providers in delivering child spacing services, the project also supports the mission's strategic objective to promote private markets.

In developing the concept for this project, USAID has focused on those areas in which A.I.D. has comparative strength, which complement the activities of other donors, and which are major constraints to child spacing in Cameroon. Bridging activities have been supported by several S&T/POP projects including Population Communication Services (JHU/PCS), Training in Reproductive Health (JHPIEGO) and Family Planning Services Expansion and Technical Support (SEATS). These projects as well as the Family Planning Training for Paramedical, Auxiliary, and Community Health Worker Personnel II (PAC II) Project will support the implementation of project activities.

D. Complementarity with Other USAID Projects and Other Donor Assistance

USAID has focused its health and population portfolio on supporting the nationwide expansion of the MOPH's reoriented PHC program which is based on decentralized planning, community co-financing and co-management of health care, and the full integration of services. Since 1989, the USAID MCH/CS project has supported the implementation of the reoriented PHC program in Adamaoua and South Provinces. In support of the program, the MCH/CS Project has developed a comprehensive training program consisting of modules on community mobilization, the establishment of community health and community management committees, the delivery of integrated and rationalized health care, the management of a drug logistics system, integrated supervision, and other PHC topics. The project supports long- and short-term technical assistance (TA), in-country training, commodity support, operations research, and participant training. By 1993, the MCH/CS Project will have introduced community co-financed and community co-managed health services into approximately 96 health areas in the two target provinces.

USAID is also funding the Reform of the Health Delivery System Project in Extreme North Province. Implemented by a PVO consortium of Save the Children and CARE, the project is launching the reoriented PHC program in the health districts of four divisions.

Other donors involved in the implementation of the reoriented PHC program include the German Cooperation in parts of Littoral, Northwest, and Southwest Provinces; UNICEF in parts of East, West, and Centre Provinces; Belgian AID in one division in Extreme North Province; and the French Cooperation in North Province. These donor projects differ in response to local circumstances and the interests of each donor.

All of these projects follow the major principles of the reoriented PHC program. The training materials developed under USAID's MCH/CS Project are beginning to be applied as standard PHC training texts for the country. Multi-donor PHC coordination meetings are convened by the MOPH on a quarterly basis to review current activities and future plans and to assure the most effective use of donor resources.

Donor Support in Child Spacing

USAID has been the lead donor in introducing child spacing information and services in Cameroon. USAID assistance began in the early 1980s with FPIA support to Djoungolo Protestant Hospital, funding for family planning in-country and participant training, and support for natural family planning services.

UNFPA began supporting child spacing information and services in 1987 through the following pilot activities:

- Integration of family planning services into eight MCH centers in Yaounde and Douala, implemented by WHO;
- IEC activities and family life education for members of the national labor union;
- Development of IEC materials and programs with the Ministry of Social and Women's Affairs; and

- Integration of IEC into the program of agricultural extension workers.

In 1991, UNFPA plans to design a child spacing program to be implemented in its 1992-1996 budget cycle.

Other donor-funded family planning/child spacing programs include the following:

- Support for national family planning services, funded by the Family Life Association of Cameroon, a Catholic Church-supported NGO.
- Support for the Cameroon National Association for Family Welfare (CAMNAFAW), funded by the International Planned Parenthood Federation (IPPF). Recognized by the government as a non-profit organization, CAMNAFAW conducts service delivery, responsible parenthood, and IEC training activities. CAMNAFAW plans to open a service delivery clinic in 1992.
- Training of service delivery personnel, provision of equipment, and renovation of centers, funded by the Japanese Cooperation through a \$1,000,000 grant implemented by the World Bank. Since signature in late 1990, no implementation plan has been developed for this activity.

3. Project Description

A. Project Goal and Purpose

The goal of the project is to improve the health of Cameroonian women, infants, and children.

The purpose of the project is to integrate quality child spacing and maternal health services into the national primary health care program in four provinces and to expand the availability of these services through religious, parastatal, and private for-profit sector facilities.

B. Expected Achievements

- Child spacing/maternal health medical standards and referral guidelines developed, tested, officially adopted and disseminated.
- Pre-service training in reproductive health strengthened through the development and integration of curricula for the national medical and nursing/midwifery schools.
- A cadre of national trainers identified and trained, and an in-service curriculum developed in child spacing/maternal health, including pre-natal and post-partum care, detection and treatment of infertility and STDs, and promotion of breastfeeding.
- Approximately 819 public sector health providers trained in child spacing/maternal health information and services.
- Approximately 455 private sector health providers trained in child spacing/maternal health information and services.
- An IEC program developed and implemented that will lead to increased demand for maternal health/child spacing services and will be consistent with the integrated strategy of the national PHC program. This program will include training in counseling and interpersonal communication; preparation, dissemination, and distribution of a variety of IEC materials; and media campaigns.
- Child spacing and maternal health interventions including diagnosis and treatment of infertility, identification and case management of STDs, strengthening pre- and post-natal care, the promotion of early and exclusive breastfeeding, and maternal high-risk assessment integrated into approximately 163 public sector health facilities and 145 private sector facilities.
- Contraceptives integrated into the PHC logistics and distribution systems.
- Low-priced condoms available nationwide through the social marketing program.
- Improved capability of DFMH staff to plan, implement, monitor and evaluate child spacing and maternal health activities.

- The official adoption of the reorientation of PHC as official MOPH policy.
- The introduction of the reorientation of PHC in an additional 10 sub-divisions in Extreme North Province.

C. End of Project Indicators

1. Contraceptive sales increased from an estimated 30,000 couple years of protection (CYP) to 120,000 CYP annually. (Couple year of protection is defined as the quantity of contraceptives necessary to protect a couple for one full year).
2. Contraceptive prevalence increased from an estimated 2 percent to 7 percent of married couples of reproductive age.
3. The number of health facilities offering quality child spacing and maternal health services increased from approximately 40 to 308 sites.
4. The contraceptive method mix evolving to reflect the utilization of more effective methods by married couples of reproductive age. The baseline contraceptive method mix will be determined by the 1991 Cameroon Demographic and Health Survey (DHS).

Evaluation of Indicators

Goal level. The 1991 DHS will provide baseline estimates of maternal, infant, and child mortality rates. These indicators will be estimated again in the 1996 DHS. It is unlikely, however, that this project will by itself have a measurable effect on these mortality rates over the life of project.

Purpose level. The 1991 DHS will provide detailed baseline data on contraceptive prevalence. The projected 1996 DHS will provide follow-up data on this indicator.

Output level. The project will be able to measure contraceptive sales and contraceptive method mix on a regular basis from data provided by the national contraceptive warehouse and service delivery sites. The national health management information system will provide data on the number of facilities offering child spacing services. The two planned demographic and health surveys will provide information on the knowledge and attitudes of the population regarding child spacing. This information will permit the monitoring of the project's IEC component.

D. Project Description

The project will have public, private, and policy reform components. The public sector component will complement USAID's Maternal Child Health/Child Survival and Reform of the Health Delivery System Projects and other donor efforts in PHC by integrating child spacing and maternal health activities into health centers and reference hospitals which are community co-managed and co-financed and are supported by PHC logistics, supervision, and health information systems.

The private sector component of the project will directly support the integration of child spacing and maternal health services in the nation's missionary hospital and clinic network, in the health clinics of large private and parastatal businesses, and in large private for-profit health facilities.

The policy reform component will assist the MOPH to adopt two critical legal texts which will permit the nationwide expansion of the reorientation of the PHC program and the integration of child spacing and maternal health services into this program.

Public Sector Component

The public sector component will harmonize the ongoing child spacing/maternal health activities of four S&T/POP Cooperating Agencies so that they can assist four provincial health delegations to integrate quality child spacing/maternal health activities into their PHC programs.

The integration of maternal health and child spacing activities into the MOPH's reoriented PHC program will be achieved by the following means:

- introduction of maternal health/child spacing into the annual plans of functioning health districts in project areas;
- introduction of contraceptives, maternal health drugs, and other essential supplies into the PHC medical supply logistics system;
- expansion of the PHC supervision and health information systems to include maternal health and child spacing components;
- involvement of community health committees in the delivery of maternal health and child spacing IEC services; and
- introduction of maternal health and child spacing services into pre-natal and under-five consultations at community co-financed and co-managed health facilities.

USAID and the MOPH have identified the following critical actions to achieve this integration:

- development of child spacing medical standards and referral guidelines to assure quality of services;
- revision of reproductive health pre-service curricula to assure that future health professionals will arrive at their posts with child spacing/maternal health training;
- elaboration of an in-service child spacing/maternal health training program to assure that practicing health workers are competent to deal with child spacing/maternal health issues;
- support of child spacing/maternal health services in health facilities in project areas by providing necessary equipment and supplies;
- development of an integrated IEC program to increase public knowledge and awareness about child spacing, to create demand for services and to enhance service provider counseling skills;

- strengthening of PHC management systems to include child spacing and maternal health concerns; and
- institution of strategic planning by the DFMH to enable the rational expansion of child spacing/maternal health services on a national scale.

Public Sector Implementing Agencies

Directorate of Family and Maternal Health. The DFMH will have overall responsibility for project implementation. In terms of specific responsibilities, the DFMH will 1) develop the technical and policy guidelines, materials, and protocols necessary to launch a national child spacing/maternal health program; 2) plan the implementation of the program; and 3) monitor and evaluate the program. This will include

- development of child spacing/maternal health medical standards and service delivery protocols;
- design, testing, production and distribution of IEC materials and programs;
- elaboration of in-service training curricula consistent with the prevailing PHC training strategy;
- design of supervision and information instruments which will be integrated into the PHC program;
- forecasting and distribution of contraceptives and equipment (purchased under the project) to the provinces;
- strategic planning for the rational expansion of child spacing/maternal health activities on a national scale; and
- harmonization and coordination of public and private sector child spacing/maternal health service delivery strategies. This will include assuring that all private sector providers employ the same medical and referral standards, in-service training curricula, and IEC programs and materials.

Provincial Health Delegations. The Provincial Health Delegations in cooperation with donor agencies supporting PHC in their provinces will have the following specific responsibilities:

- planning the launch of child spacing/maternal health activities into their provinces by including these activities into provincial PHC implementation plans;
- assuring through guidance and directives that health districts include the launching and implementation of child spacing and maternal health services in their annual PHC plans;
- identifying provincial child spacing/maternal health trainers and training sites;
- assuring that the health districts implement the training and other activities necessary to integrate child spacing/maternal health fully into the PHC service delivery system; and

- assuring (by means of the Provincial Pharmaceutical Teams) that contraceptives, maternal health equipment and drugs, IEC materials, and other supplies are placed into the provincial drug and medical supply system and that intermediate depots and hospital and health center pharmacies maintain a steady and adequate supply of these commodities.

The DFMH representative on the Provincial Health Team will play a key role in the above activities.

Directorate of Preventive and Rural Medicine. In its role as the overall coordination and implementation agency for the national PHC program, the DPRM will assure the effective integration of child spacing/maternal health activities into provincial service delivery systems. The DPRM will assure that child spacing/maternal health supervision and information guidelines are effectively integrated into the PHC supervision and information systems. In addition, the DPRM will assure that the IEC and training strategies and materials developed by the DFMH are compatible with the PHC program and are effectively integrated into the program. In this regard, the DPRM will provide input into the elaboration of training and IEC materials and programs.

Directorate of Hospital Services. The DHS will assist in the development and implementation of maternal health/child spacing medical standards and protocols. The DHS will also assist in the development of maternal health/child spacing curricula and the review of supervision protocols.

Cameroon University Center of Health Sciences. CUSS will provide technical guidance for the development of medical standards and protocols and training plans. In addition, CUSS will conduct a trial of Norplant under a sub-agreement with JHPIEGO and, in collaboration with the National Epidemiological Research Board, will coordinate operations research activities in maternal health/child spacing over the life of the project. Finally, CUSS will implement the pre-service training component of the Project.

USAID-Funded Implementing Agencies

The project will implement child spacing and maternal health interventions through buy-ins to four ST/POP projects all of which by project start-up will have considerable experience implementing child spacing activities in Cameroon. The buy-ins will be linked into a comprehensive program of the DFMH which will oversee the national child spacing program and coordinate the donors involved in this sector. The SEATS Project will provide technical assistance in order to enhance the coordinating and strategic planning capacity of the DFMH. As such, SEATS will serve as the lead A.I.D. cooperating agency involved in the implementation of this project. The project personal services contractor (PSC) will assist SEATS in its coordinating role by assuring that all A.I.D. inputs are provided in a timely and effective manner. With assistance from the USAID Contracts Officer, SEATS will conduct a two day workshop outlining basic procurement and customs procedures for MOPH staff responsible for clearing commodities from the air and sea ports. Special attention will be focused on explaining guidelines for commodity procurement within the host country.

Public Sector Activities

The project will integrate quality child spacing and maternal health activities into approximately 163 MOPH health centers and reference hospitals in four provinces where the revised PHC strategy is being initiated. (This represents approximately 15 percent of all public health facilities in the country.) Maternal health activities will include infertility diagnosis and treatment, strengthening pre- and post-natal care, identification and case management of STDs, the promotion of early and

exclusive breastfeeding, and maternal high risk assessment. The targeted provinces are as follows: Extreme North, Adamaoua, and South (PHC program presently funded by USAID), and Central (PHC program to be funded by UNICEF beginning in 1991). The first three of these provinces were chosen because of the ongoing USAID PHC assistance in these areas. Central Province was chosen because of its high population density and because of its proximity to the city of Yaounde. To the extent possible, the health centers and reference hospitals targeted under the project will have the following profile as outlined by the revised PHC program:

- a functioning community health committee to co-manage the health facility;
- a revolving-fund drug store (and other health cost recovery measures) managed by the community health committee; and
- fully integrated PHC services supervised by the health district team.

Maternal and child health centers (PMIs) represent a key referral and service delivery site for child spacing and maternal health activities. The project will provide technical and material assistance to the four targeted provinces to fully integrate the PMIs into the PHC program. Due to the linkage of the child spacing/maternal health program to the national PHC program, service delivery expansion under this project will be coordinated with the expansion of PHC activities. As a result of its integration into the revised PHC program, the child spacing program will become part of a sustainable, financially viable, and community-managed health care delivery system.

Medical Standards, Referral Guidelines, and In-service Training

a. Through a buy-in to the Family Planning Training for Paramedical Auxiliary and Community Health Worker Personnel II (PAC-II) Program, the project will assist the DFMH to develop child spacing/maternal health standards (including quality of care guidelines), service delivery protocols, and reference and continuity of care guidelines by type of facility. These guidelines, protocols, and standards will conform to the overall structure for primary, secondary, and tertiary care established by the MOPH. The DFMH will convene a committee of experts to draft the standards and protocols which will be based on and which will complement national pre-service reproductive health curricula for medical and paramedical personnel. The DFMH will be responsible for ensuring their adoption, dissemination, and promotion throughout the public and private health system.

b. Upon approval of standards and protocols by the MOPH, the DFMH will design a national child spacing/maternal health training program which conforms to the guidelines established for in-service training by the national PHC program. Implementation steps area as follows:

- Establishment of a pool of national reproductive health experts to serve as national trainers and preceptors in child spacing and maternal health. The national trainers, consisting of faculty members from CUSS, the nurse training schools, and at least two senior practitioners from each of the targeted provinces will be trained in the following areas: advanced reproductive health, the national PHC strategy, pedagogy, PHC logistics, supervision, evaluation, and IEC. Training will likely take place at health facilities in Yaounde and Douala.
- Development by the national trainers of a child spacing/maternal health in-service curriculum which conforms to the MOPH's PHC program.

- Training of district (sub-divisional level) PHC training teams in child spacing and maternal health. The trainers will include provincial practitioners who are members of the national training team. Training will take place in provincial or divisional hospitals.
- Basic and refresher training by the district PHC teams of 1-2 service providers by targeted health center, and 2-3 service providers by targeted reference hospital or PMI in child spacing and maternal health. Training will likely take place in the sub-divisional hospitals. Some trainees will conduct supervised IUD insertions both during their training and at their sites (supervised by visiting practitioners) until minimum competency (i.e., 10 successful insertions) is reached.
- Provision of technical and reference materials for national trainers, the DFMH, and provincial personnel and service providers.

Pre-service Training and Operations Research

Through a contract with the JHPIEGO program, the project will strengthen the reproductive health curricula in Cameroon's nursing/midwifery and medical schools by revising training modules, developing lesson plans, providing refresher training for tutors, equipping practical training sites, and providing training and resource materials. Activities will include

- didactic and clinical reproductive health training for faculty members from the nursing/midwifery schools;
- curriculum and lesson plan development workshops for faculty members from the nursing/midwifery schools (modules to be developed will cover newborns, STDs and AIDS, infertility, and gynecology);
- training of trainers courses in reproductive health and education skills for faculty trainers from the medical and nurse/midwifery schools;
- evaluation of the teaching of the existing reproductive health modules (i.e., pre-natal, intra-partum, post-partum and child spacing) at the medical and nursing/midwifery schools and revision of those modules, if necessary;
- provision of educational and audio-visual materials;
- provision of appropriate equipment and supplies for infertility diagnosis to three provincial hospitals and training of OB/GYNs in advanced infertility diagnosis and treatment; and
- a field trial of Norplant, a contraceptive implant, to be conducted by senior professors at CUSS.

These activities will be implemented through a sub-agreement between JHPIEGO and CUSS in cooperation with the DFMH. The training activities will be carried out by senior faculty members from CUSS and the nursing/midwifery schools.

Strategic Planning and Integrated Service Delivery

Under a buy-in with the S&T/POP Family Planning Service Expansion and Technical Support (SEATS) Program, the Project will provide technical assistance to the DFMH to plan strategically the expansion of child spacing and maternal health services in Cameroon in the context of the national PHC program. Strategic planning will emphasize the effective integration of various components (training, services, IEC, social marketing, etc.) and sectors (public, parapublic, religious, and private for-profit) and the strengthening of management and quality of care systems.

This component will also significantly reinforce the DFMH's capacity to coordinate the donors involved in child spacing and maternal health. The DFMH will achieve this coordination by outlining a clear national child spacing/maternal health program linked to the national PHC strategy; publishing medical standards, service delivery protocols, and a standard in-service curriculum; establishing child spacing/maternal health components for integrated management systems; and providing standardized but culturally appropriate IEC materials for the country. Thus, prospective donors in child spacing/maternal health will have clear guidance on all phases of program implementation.

The project will support the DFMH's strategy to integrate child spacing and maternal health activities into the national PHC program. Support for service delivery will include

- the provision of essential maternal health/child spacing equipment, as required, to targeted service sites. This includes the provision of mini-laparotomy kits to provincial or divisional hospitals in which physicians have been trained.
- the provision of contraceptives to community-managed revolving fund pharmacies. Contraceptives will be distributed from the DFMH's national contraceptive warehouse. These contraceptives will enhance the cost recovery programs of the service sites and generate income to support integrated PHC supervision, outreach, refresher training, and other primary health care operating costs.
- the provision of start-up supplies of medicines for maternal health (including STD treatment), and laboratory equipment and reagents to detect STDs.
- the training of hospital-based physicians in mini-laparotomy.
- integration of a module on child spacing/maternal health in the national health management information system.
- the maintenance of provisional management and supervision systems for pilot service delivery sites not yet fully operational under the revised PHC program.

Information, Education, and Communication

Through a contract with the S&T/POP Population Communication Services (PCS) Program, the Project will assist the DFMH's Health Education Division to develop, implement, and evaluate integrated IEC programs to support the national PHC strategy. Specific messages on child spacing, responsible parenthood, prolonged breastfeeding, pre- and post-natal care services, and STD and infertility prevention will be developed as part of a comprehensive PHC IEC strategy. The delivery

of IEC programs will be coordinated with the availability of services. The long-term IEC advisor who will be engaged to work under the USAID-funded MCH/CS Project beginning in mid-1991 will have a counterpart named in the Health Education Division of the DFMH to insure IEC coordination between the Maternal Health and PHC programs.

The project will have three main approaches to delivering child spacing and maternal health messages:

- counseling during regular pre-natal, under-five, and curative consultations which are conducted at community-managed PHC facilities;
- sensitization of community health committees, traditional and religious leaders, health sector personnel, and national leaders; and
- motivation and demand generation in the catchment areas surrounding the health facilities once child spacing and MCH services are available.

Specific IEC activities will include

- conducting limited formative and qualitative research in order to develop integrated IEC strategies and messages;
- developing and testing specific IEC materials and conducting campaigns;
- inclusion of IEC counseling in all in-service training courses;
- developing and implementing a program to train social workers of the Ministry of Social and Women's Affairs and extension workers of the Ministry of Agriculture in population-based IEC programs in areas where the PHC program is operational; and
- provision of audio-visual equipment and supplies to the DFMH.

Private Sector Component

Religious Sector. With the assistance of SEATS, the project will support the integration of quality child spacing and maternal health information and services in the health programs of 20 missionary hospitals (and in up to 60 of their satellite clinics) which are members of the Federation of Evangelical and Mission Churches (FEMEC). Child spacing activities are presently being conducted in three of these hospitals and some of their satellite clinics. Support activities will include

- provision of child spacing/maternal health medical standards;
- provision of essential child spacing/maternal health equipment as required;
- provision of first-year supplies of contraceptives;
- technical training of health staff in child spacing and maternal health interventions (trainers will include practitioners from the Bansa, Djongolo, and Mbo Protestant Hospitals which will serve as the training sites);

- training of physicians from Mbo, Djongolo, and Banso and other interested hospitals in mini-laparotomy;
- provision of first-year supplies of child spacing/maternal health client forms; and
- provision of IEC materials and training of health staff in child spacing/maternal health counseling.

Activities in this component will be managed under a subcontract between the SEATS Program and FEMEC.

Private For-Profit and Parastatal Sectors. With the assistance of SEATS, the project will support integration of quality child spacing and maternal health information and services into the health clinics of large businesses and parastatal entities. Among these organizations are the Cameroon Development Corporation (with 3 hospitals and 19 clinics), the National Workers Union clinic in Yaounde, breweries in Yaounde and Douala, and approximately 15 other companies. The project will also support the integration of child spacing and maternal health services in approximately 20 large, private for-profit health clinics. Support activities will include

- provision of child spacing/maternal health medical standards;
- sensitization of managers regarding the cost-benefits of child/maternal health activities;
- provision of essential child spacing/maternal health equipment, as required;
- provision of free first-year supplies of contraceptives (from the DFMH contraceptive warehouse supplied by USAID) (after the first year, the participating organization or business may purchase the contraceptives from the national contraceptive warehouse or from other sources);
- training of private health practitioners in child spacing and maternal health issues and interventions (the national child spacing/maternal health trainers put in place by the project will conduct the training; practical training sites will be determined);
- training of selected hospital-based physicians in mini-laparotomy;
- provision of IEC materials and training of health workers in motivation and counseling methodologies; and
- provision of first-year supplies of the MOPH's child spacing client forms and registers.

A SEATS resident advisor will be engaged to coordinate and provide logistics and technical assistance to the project's private sector component. The resident advisor will be located at one of the major private sector organizations cooperating with the project.

Coordination Between Public and Private Sector

The DFMH will ensure the overall coordination between public and private sectors by the following measures:

- the provision of maternal health medical standards for the country;
- the provision of a standard maternal health in-service curriculum;
- the development, production, and distribution of standard IEC materials and programs;
- periodic technical supervision; and
- the processing and analysis of service delivery statistics.

Commodity Support for the National Condom Social Marketing Program

The project will procure condoms to support the national social marketing program over the life of the project. Population Services International (PSI) is currently providing technical assistance to a private sector firm in social marketing techniques including advertising, marketing, logistics, and training of local distributors. By 1997, it is expected that the program will have made significant progress toward self-sufficiency and will require reduced commodity support from USAID. The program will conduct a sustainability study in 1991 which will develop strategies to assure long-term financial sustainability.

Policy Reform Component

The objective of this component will be to assist the MOPH in the successful implementation of its program for the reorientation of PHC in Cameroon and to integrate family planning and maternal health services into this program. Under this component, the MOPH will issue two important official texts: an "arrete ministeriel" signed by the Minister of Public Health which declares the reorientation of PHC as official MOPH policy, and a "note de service" signed by the Minister of Health which officially adopts the family planning/maternal health service delivery policies and medical standards required for the integration of family planning and maternal health into the program. The adoption of these texts will be the conditions precedent for the release of funds for the expansion of the reorientation of PHC to approximately 10 sub-divisions in Extreme North Province which do not presently benefit from donor support.

This component was designed to lend support to the present favorable climate for policy reform in the health sector. Although the two reforms included in this component cannot resolve all of the policy constraints to PHC, they address two key reforms which are non-controversial and which are sequentially important at this stage of program implementation. These reforms are critical to the long-term sustainability of child spacing/maternal health services in Cameroon. The adoption of the reorientation of PHC as official health policy is a key step to institutionalizing PHC based on community co-financing and co-management of services. Without a financially viable PHC program supported by the populace, the MOPH cannot effectively deliver and sustain child spacing and maternal health services. The official adoption by the MOPH of the child spacing/maternal health medical standards developed under this project will provide a coherent national framework for the safe and effective delivery of clinical and community-based services and will provide a means to coordinate public and private sector service delivery programs.

The funds made available under this component (following the meeting of the conditions precedent) will be used to expand the PHC program to the areas of Extreme North Province which presently have no donor support. Once the PHC program is introduced, the project will assist the MOPH to

introduce child spacing/maternal health services as part of the integrated PHC service delivery program.

The funds provided under this component will be used for the following purposes:

- a. The purchase of essential drugs to be used as investment stocks for creation of community managed drug stores and initiation of cost recovery;
- b. Other commodities such as clinic equipment and supplies to permit community co-managed and co-financed health centers to adequately deliver the integrated services contained in the reoriented PHC program;
- c. The purchase of commodities required for the delivery of child spacing and maternal health services; and
- d. The in-country training of health personnel and community managers in all aspects of the reorientation of PHC and in delivery of fully integrated child spacing and maternal health services.

Implementation Arrangements

Commodities. USAID will directly procure commodities under this component.

In-country Training. USAID will advance funds under a sub-grant agreement for in-country training to an American PVO operating in Cameroon. Training activities will include:

- sensitization meetings for sub-divisional level health committees (1/2 day);
- training of health center workers in the reorientation of PHC (2 weeks);
- sensitization of health center communities (1 day);
- training of community health committees at the level of the health centers (3 days);
- training of community management committees at the level of the health center (5 days);
- training of health management committees at the level of the sub-division (3 days); and
- technical in-service training in child spacing/maternal health.

The health districts chosen for assistance under this component will be selected according to the following criteria:

- the availability of fully staffed sub-divisional health teams;
- the existence of viable health facility structures; and
- the willingness of target populations to participate in the program.

Conditions Precedent

(1) Reform: Official adoption of PHC strategy as MOPH policy

Action(s): Promulgation of an "arrete ministeriel" signed by MOPH declaring the reorientation of PHC based upon the elements of community co-management; community co-financing; availability of essential drugs and integrated service delivery as official national health policy.

Background: Although an outline for the reorientation of PHC services was circulated in 1989 and the MOPH has, with donor assistance, undertaken the implementation of the reorientation strategy in parts of all 10 provinces, the MOPH has not officially declared the strategy as policy. As a result, MOPH personnel in certain areas have been reluctant to participate in implementation efforts. In addition, there is currently confusion among health personnel as to the exact nature of the reorientation and its effect on their roles and responsibilities. This step is important in that it will legitimize efforts to develop community participation in the management and financing of health services. A document must be prepared by the MOPH that contains a clear statement recognizing the reorientation of PHC as national health policy and a priority of the MOPH. This policy document must then be officially adopted and signed by the Minister of Public Health and publicized to both health personnel and the population. Such measures are necessary in order to maintain continuity of action within programs and projects should personnel changes within the MOPH take place.

Step(s) required: The MOPH must draft and adopt (signature of the Minister of Public Health) an official "arrete ministeriel" which recognizes PHC as defined in the reorientation strategy as official MOPH policy. This "arrete" must specifically state that PHC policy will be based upon the principles of community co-management; community co-financing; availability of essential drugs; and full integration of services.

Technical assistance required: The drafting and adoption of such an "arrete" is within the means of the MOPH and as such no TA will be required.

Budget: \$300,000 (sufficient funding to launch PHC activities in approximately six sub-divisions).

(2). Reform: Development and adoption of service delivery and medical standards for maternal health and family planning (MH/FP) activities.

Action(s): Adoption of a "note de service" by the Minister of Public Health that clearly defines the service delivery policy and medical standards required for the integration of MH/FP activities into the PHC program.

The development of a family planning/maternal health service delivery policy, including medical standards, is an essential first step in the national initiative to integrate child spacing services into the primary health care program. A national service delivery policy will define the roles of individual health workers in the delivery and support of these services. The policy will also provide authorization and reference points for service delivery. The medical standards will establish quality of care criteria for training and supervision of services. Method protocols must be developed (or adapted from existing models) for precise guidance in the delivery of each available family planning service. The service policy and medical standards developed and adopted as a whole will provide a coherent national framework for the safe and effective delivery of clinical services and related community-based services.

The development and adoption of such standards will require the MOPH to obtain a wide consensus of the medical community including academicians, researchers, public and private sector service providers, and health managers and administrators. In addition, it will be necessary for the MOPH to establish a process to review the standards periodically in order to ensure that they continue to be appropriate to the needs of the population, and are consistent with emerging medical technology.

Steps required: The MOPH will draft service delivery policy and medical standards for maternal health/family planning services. The MOPH will then draft a "note de service", signed by the Minister, approving these standards for application in all public and private health facilities in Cameroon.

Technical Assistance: The technical assistance required for this action will be provided through the project's buy-in to the PAC-II Program.

Budget: \$200,000 (sufficient funding to launch PHC activities in approximately four sub-divisions).

4. Cost Estimates and Financial Plan

A. U.S. Financial Inputs

Most of the proposed USAID project inputs will be implemented through buy-ins to the worldwide contracts or cooperative agreements between A.I.D./Washington's Office of Population (S&T/POP) and four cooperating agencies. The proposed cooperating agencies are John Snow, Inc. (SEATS), JHPIEGO, JHU/PCS, and INTRAH (PAC II). In addition, USAID will provide condoms for the social marketing program managed by PSI. The four cooperating agencies will make maximum use of Cameroonian professionals for short-term technical assistance when local expertise is available. U.S. long-term and short-term technical assistance will be utilized to assist Cameroonians in project implementation and to transfer skills through on-the-job training of Cameroonian counterparts. A summary of proposed USAID project inputs follows.

1. SEATS
 - a. Long-term Technical Assistance
 - (1) Advisor to DFMH, 5 person years
 - (2) Private Sector Advisor, 5 person years
 - b. Short-term Technical Assistance, 24 person months
 - c. In-country Training, 46 courses for 520 participants
 - d. Commodities, 2 computers, printers and software
2. PAC II
 - a. Short-term Technical Assistance, 14 person months
 - b. In-country Training, 38 courses for 688 participants
3. JHPIEGO
 - a. Short-term Technical Assistance, 6 person months
 - b. Commodities, 3 laparoscopes
 - c. In-country Training, 3 courses for 26 participants
 - d. Local Procurement, sub-contract with CUSS for Norplant trials
4. JHU/PCS
 - a. Short-term Technical Assistance, 21 person months
 - b. In-country Training, 3 courses for 40 participants

- c. Local Procurement, contracts for video productions, radio productions, IEC research and printing of booklets, leaflets, posters, and client forms

5. USAID

- a. Procurement of contraceptives through A.I.D./Washington's system, including 2.5 million cycles of oral contraceptives, 20 million condoms, and 75,000 IUDs
- b. Commodities, mini-laparotomy kits, laboratory equipment and reagents, MCH equipment, MCH drugs, and 1 vehicle, plus freight
- c. Costs of mid-term and final project evaluations
- d. \$250,000 of commodities (drugs and equipment) for Policy Reform component
- e. \$250,000 for training courses in PHC for Policy Reform Component
- f. USAID Project Manager hired under personal services contract, 4.5 person years
- g. 5 percent reserve for inflation and contingency

B. Host Country Financial Input

The Government of the Republic of Cameroon will make in-kind contributions minimally of US\$ 3,137,500 over the LOP, equal in value to 39 percent of USAID's contribution to the project. The value of the GRC's in-kind contribution was estimated as follows:

GRC's Budget for Health Sector (1990/1):	FCFA 22.75 billion
Percent Allocated to Salary Payments	80%
Percent of MOPH PHC Staff in Provinces under the Project:	20%
Percent of Staff Time Allocated to Family Health Activities:	5%

FCFA 290 US\$ 1.00

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Estimated Value of GRC In-kind Contribution per Year	US\$ 627,500
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Estimated Value of GRC In-kind Contribution over LOP	US\$ 3,137,500
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In addition, the GRC will provide in-kind contributions to the project in the form of: i) use of government training facilities, ii) use of service delivery sites, and iii) space at the Central Warehouse of ONAPHARM. The individuals and communities which will benefit from the family health services which will be promoted under this project will also contribute to the sustainability of these activities through user fee payments at private and public sector health institutions. A rough estimate of the

cash payments to the PHC systems in the four provinces would be US \$4.0 million over the life of the project, with a portion of this attributed to the provision of MCH-related services.

C. Financial Management

USAID will finance bi-annual program reviews of the procurement, storage, and distribution of contraceptives by the Ministry of Public Health, as well as the religious, parapublic, for-profit private sector institutions involved in the project.

Because the overwhelming majority of project assistance funds will be committed through buy-ins with U.S. firms which are required by A.I.D./Washington to be audited annually and for contraceptives procured through A.I.D./Washington, financial audits of these project components are not contemplated. The institutional contractors will be responsible for contracting locally with independent auditors for non-federal reviews of sub-project activities in Cameroon. Funds for such reviews will be included in the contractors' budgets. Reviews will be expected at least every 18 months.

Table 1: SUMMARY COST ESTIMATE AND FINANCIAL PLAN

SOURCE	INPUT QUANTITY	USAID FX	TOTAL LC	LOP
A. LONG TERM T.A.				\$587,500
				=====
1. SEATS	10 pers yrs		\$250,000	\$250,000
2. PSC	.5 pers yrs		\$337,500	\$337,500
B. SHORT-TERM T.A.				\$896,980
				=====
1. SEATS	24 person mth	\$227,920	\$38,000	\$265,920
2. PAC II	14 person mth	\$157,500		\$157,500
3. JHPIEGO	6 person mth	\$75,000		\$75,000
4. JHU/PCS	21 person mth	\$159,060	\$38,000	\$197,060
5. Evaluation	10 person mth	\$201,500		\$201,500
C. COMMODITIES				\$2,771,919
				=====
1. Condoms	20.0 million	\$980,000		\$980,000
2. Oral Cycles	2.5 million	\$560,000		\$560,000
3. IUDs & Kits	75,000	\$100,130		\$100,130
4. MCH Drugs	150 centers	\$150,000		\$150,000
5. MCH Equipmt	150 centers	\$300,000		\$300,000
6. Laparoscopes	3 scopes	\$15,000		\$15,000

7. Vehicles	1 vehicle	\$35,000		\$35,000
8. Computers	2 comptr/print	\$10,000		\$10,000
9. Freight		\$621,789		\$621,789
D. LOCAL COSTS				\$2,692,741
				=====
1. Training	1274 trainees		\$2,303,789	\$2,303,789
2. Norplant	500 women		\$150,000	\$150,000
3. IEC Material			\$190,952	\$190,952
4. IEC Rsch			\$23,000	\$23,000
5. Other			\$25,000	\$25,000
E. REFORM COMPONENT				
				\$500,000
				=====
1. Training			\$250,000	
2. Commodities		\$250,000		
F. INFLATION/ CONTINGENCY				
		\$600,860		\$600,860
TOTAL		\$4,781,259	\$3,268,741	\$8,050,000

Table 2: PROJECTION OF
EXPENDITURES BY FISCAL
YEAR

FISCAL YEAR	USAID	HOST COUNTRY	TOTAL
FY 1991/2	\$2,150,000	\$627,500	\$2,777,500
FY 1992/3	\$1,291,615	\$627,500	\$1,919,115
FY 1993/4	\$1,604,740	\$627,500	\$2,232,240
FY 1994/5	\$1,391,550	\$627,500	\$2,019,050
FY 1995/6	\$1,011,245	\$627,500	\$1,638,745
INFLATION/ CONTINGENCY	\$600,850		\$600,850
	=====	=====	=====
GRAND TOTAL	\$8,050,000	\$3,137,500	\$11,187,500

D. Methods of Implementation and Financing

The table below shows the methods of implementation and financing for the project. These methods have been approved previously in the mission's General Assessment and do not require any further justification of the Payment Verification Policy Implementation Guidance. As shown in the table below, all project inputs, with the exception of evaluation, audit, and some commodity procurement, will be implemented under direct contracts with or grants with ST/POP cooperating agencies. Evaluation, audit, and the commodity procurement will be implemented through direct A.I.D. contracts with either profit or non-profit organizations in the U.S.

Method of Implementation	Method of Financing	Approximate Amount
<u>TA, Training and Commodities</u>		
Direct contracts or grants with ST/POP Cooperating Agencies	Direct Payment or LOC	\$4,215,721
PSC - direct contract	Direct Payment	337,500
<u>Evaluation/Audit</u>		
Direct contract (profit or non-profit institution)	Direct Payment	201,500
<u>Commodity Procurement</u>		
	Direct Payment	2,694,429
<u>Contingency</u>		
	-----	600,850
TOTAL		\$8,050,000

As host country contracting will not be utilized in regard to AID funds, a detailed explanation and assessment of the host country government's specific procedures for contracting and payment verification is not required. Since A.I.D. funds (estimated at \$4,215,721) will be implemented through buy-ins with ST/POP cooperating agencies, only a minimal level of USAID involvement in exercising the day-to-day oversight of accountability will be required.

Table 1: DETAILED BUDGET ESTIMATES
FAMILY PLANNING SUPPORT PROJECT

IMPLEMENTING ORGANIZATION ITEM	UNIT COST	UNIT OF MEASURE	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5		TOTAL LCP
			# OF UNITS	\$ OF BUDGET									
SEATS (JSI)													
=====													
FOREIGN EXCHANGE													
1. TR/Monitoring													
Short-term	\$12,500	month	4	\$50,000	4	\$50,000	2	\$25,000	2	\$25,000	2	\$25,000	\$175,000
2. Overhead													
	\$3,780	70% salary	4	\$15,120	4	\$15,120	2	\$7,560	2	\$7,560	2	\$7,560	\$52,320
LOCAL CURRENCY													
1. Technical Assist													
Long-term	\$62,500	year	2	Core	2	Core	2	\$50,000	2	\$95,000	2	\$125,000	\$250,000
Short-term	\$7,500	month	2	\$7,500	2	\$7,500	2	\$7,500	2	\$7,500	2	\$7,500	\$38,000
2. Training: TOT (2 wk)													
Participant	\$1,050	person	10	\$10,500	10	\$10,500	0	\$0	0	\$0	0	\$0	\$21,000
Other Support	\$2,500	course	1	\$2,500	1	\$2,500	0	\$0	0	\$0	0	\$0	\$5,000
3. Training: Clin (3 wk)													
Trainers Expense	\$1,400	wk	12	\$16,800	24	\$33,600	30	\$42,000	21	\$29,400	0	\$0	\$121,800
Participant	\$1,800	person	40	\$72,000	60	\$108,000	100	\$180,000	70	\$126,000	0	\$0	\$522,000
Other Support	\$3,000	course	4	\$12,000	3	\$24,000	10	\$30,000	7	\$21,000	0	\$0	\$87,000
4. Training: Minilab (8 days)													
Participant	\$1,250	person	42	\$52,500	42	\$52,500	42	\$52,500	42	\$52,500	42	\$52,500	\$262,500
Other Support	\$2,000	course	3	\$6,000	3	\$6,000	3	\$6,000	3	\$6,000	3	\$6,000	\$30,000
5. Other													
Computer/Prntr	\$5,000	unit	2	\$10,000	0	\$0	0	\$0	0	\$0	0	\$0	\$10,000
=====													
SUB-TOTAL SEATS				\$255,020		\$345,320		\$380,560		\$370,060		\$223,560	\$1,575,220

PAC II PROJECT

FOREIGN EXCHANGE

1. Technical Assist

TOT Course	\$12,500 month	4	Pre-funded	0	\$0	2	\$25,000	0	\$0	0	\$0	\$25,000
Preceptor	\$12,500 month	4	\$50,000	0	\$0	2	\$25,000	0	\$0	0	\$0	\$75,000
Basic MCH/FP	\$12,500 month	1	\$12,500	0	\$0	0	\$0	0	\$0	0	\$0	\$12,500
Update w/o IUD	\$12,500 month	0	\$0	0	\$0	0	\$0	0	\$0	0	\$0	\$0
Update w/IUD	\$12,500 month	0	\$0	1	\$12,500	0	\$0	0	\$0	0	\$0	\$12,500

2. Overhead	26% cost		\$16,250		\$3,250		\$13,000		\$0		\$0	\$32,500
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LOCAL CURRENCY

1. Training: TOT (3 wk)

Participant	\$1,525 person	20	\$30,500	0	\$0	10	\$15,250	0	\$0	0	\$0	\$45,750
Other Support	\$3,000 course	2	\$6,000	0	\$0	1	\$3,000	0	\$0	0	\$0	\$9,000

2. Training: Precept (3 wk)

Trainers Expense	\$1,400 wk	3	\$8,400	0	\$0	2	\$4,200	0	\$0	0	\$0	\$12,600
Participant	\$1,300 person	20	\$26,000	0	\$0	10	\$13,000	0	\$0	0	\$0	\$39,000
Other Support	\$3,000 course	2	\$6,000	0	\$0	1	\$3,000	0	\$0	0	\$0	\$9,000

3. Training: Basic w/o IUD (3 wk)

Trainers Expense	\$1,400 wk	3	\$8,400	3	\$8,400	7	\$12,600	3	\$8,400	0	\$0	\$37,800
Participant	\$1,135 person	40	\$45,400	40	\$45,400	60	\$68,100	40	\$45,400	0	\$0	\$204,300
Other Support	\$3,000 course	2	\$6,000	2	\$6,000	2	\$9,000	2	\$6,000	0	\$0	\$27,000

4. Training: Basic w/ IUD (4 wk)

Trainers Expense	\$1,400 wk	3	\$11,200	3	\$11,200	12	\$16,800	3	\$11,200	0	\$0	\$50,400
Participant	\$1,300 person	40	\$72,000	40	\$72,000	60	\$108,000	40	\$72,000	0	\$0	\$324,000
Other Support	\$3,000 course	2	\$6,000	2	\$6,000	2	\$9,000	2	\$6,000	0	\$0	\$27,000

5. Training: Update w/o IUD (2 wk)

Trainers Expense	\$1,400 wk	0	\$0	0	\$0	5	\$8,400	10	\$14,000	0	\$0	\$22,400
Participant	\$770 person	0	\$0	0	\$0	60	\$46,200	100	\$77,000	0	\$0	\$123,200
Other Support	\$2,500 course	0	\$0	0	\$0	3	\$7,500	5	\$12,500	0	\$0	\$20,000

6. Training: Update w/ IUD (3 wk)

Trainers Expense	\$1,400 wk	0	\$0	5	\$8,400	7	\$12,600	12	\$16,800	0	\$0	\$37,800
Participant	\$1,435 person	0	\$0	24	\$34,440	36	\$51,660	48	\$68,880	0	\$0	\$154,980
Other Support	\$3,000 course	0	\$0	2	\$6,000	3	\$9,000	4	\$12,000	0	\$0	\$27,000

SUB-TOTAL PAC II			\$314,650		\$210,590		\$465,310		\$350,180		\$0	\$1,340,730
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JHPIESO

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FOREIGN EXCHANGE

1. TA/Monitoring

Short-term	\$12,500 month	1	\$12,500	2	\$25,000	2	\$25,000	1	\$12,500	0	\$0	\$75,000
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2. Commodities

Laparoscopes	\$5,000 scope	3	\$15,000	0	\$0	0	\$0	0	\$0	0	\$0	\$15,000
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3. Overhead

72%cost			\$8,800		\$8,000		\$8,000		\$4,000		\$0	\$28,600
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LOCAL CURRENCY

1. Training: Lapscope

Participant	\$835 person	0	\$0	6	\$5,010	0	\$0	0	\$0	0	\$0	\$5,010
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Other Support	\$2,000 course	0	\$0	1	\$2,000	0	\$0	0	\$0	0	\$0	\$2,000
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2. Training: STD

Participant	\$835 person	10	\$8,350	10	\$8,350	0	\$0	0	\$0	0	\$0	\$16,700
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Other Support	\$2,000 course	1	\$2,000	1	\$2,000	0	\$0	0	\$0	0	\$0	\$4,000
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3. Norplant Trial

\$50,000 year		0	\$0	1	\$50,000	1	\$50,000	1	\$50,000	0	\$0	\$150,000
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SUB-TOTAL JHPIESO

			=====		=====		=====		=====		=====	=====
			\$46,650		\$100,360		\$83,000		\$66,500		\$0	\$296,510

JHU/PSC												
=====												
FOREIGN EXCHANGE												
1. Technical Assist												
Short-term	\$15,500 month	4	\$12,000	2	\$46,500	2	\$31,000	1	\$15,500	1	\$15,500	\$120,500
			(partfunded)									
2. Overseas Broadcast												
			\$3,340		\$14,380		\$9,920		\$4,960		\$4,960	\$38,550
LOCAL CURRENCY												
1. Technical Assist												
Short-term	\$3,300 month	4	\$15,200	2	\$7,600	2	\$7,500	2	\$7,500	0	\$0	\$38,000
2. Training:TOT (4 wk)												
Participant	\$1,425 person	15	\$21,375	0	\$0	15	\$21,375	0	\$0	0	\$0	\$42,750
Other Support	\$8,000 course	1	\$8,000	0	\$0	1	\$8,000	0	\$0	0	\$0	\$16,000
3. Journalist Sensitization (1 wk)												
Participant	\$450 person	10	\$4,500	0	\$0	0	\$0	0	\$0	0	\$0	\$4,500
Other Support	\$1,000 course	1	\$1,000	0	\$0	0	\$0	0	\$0	0	\$0	\$1,000
4. IEC Materials												
Flyers	\$0.17 flyer	0	\$0	600000	\$103,448	0	\$0	0	\$0	0	\$0	\$103,448
Posters	\$1.58 poster	0	\$0	4000	\$5,517	0	\$0	0	\$0	0	\$0	\$5,517
Audio Cassette	\$8.32 2 casset	800	\$6,656	0	\$0	0	\$0	0	\$0	0	\$0	\$6,656
Flip Charts	\$41.53 1 chart	500	\$20,760	0	\$0	0	\$0	0	\$0	0	\$0	\$20,760
Radio Campaign	\$2,000 program	0	\$0	4	\$8,000	4	\$8,000	4	\$8,000	4	\$8,000	\$32,000
Radio Serial	\$200 episode	0	\$0	52	\$10,400	0	\$0	0	\$0	0	\$0	\$10,400
Video Prodn	\$5,000 video	2	\$10,000	0	\$0	0	\$0	0	\$0	0	\$0	\$10,000
Video Quardistr	\$20 copy	100	\$2,000	0	\$0	0	\$0	0	\$0	0	\$0	\$2,000
5. Research												
Baseline	\$8,000 survey	1	\$8,000	0	\$0	0	\$0	0	\$0	0	\$0	\$8,000
Monitoring	\$1,250 year	0	\$0	1	\$1,250	1	\$1,250	1	\$1,250	1	\$1,250	\$5,000
Evaluation	\$10,000 study	0	\$0	0	\$0	0	\$0	0	\$0	1	\$10,000	\$10,000
6. Other												
Local Costs	\$5,000 year	1	\$5,000	1	\$5,000	1	\$5,000	1	\$5,000	1	\$5,000	\$25,000
=====												
SUB-TOTAL PSC			\$118,501	\$202,595	\$92,145	\$42,510	\$44,710	\$500,251				

USAID/CAMEROON

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FOREIGN EXCHANGE

1. Technical Assist

Midterm Evaltn	\$20,150	month	0	\$0	0	\$0	5	\$100,750	0	\$0	0	\$0	\$100,750
Final Evaluatn	\$20,150	month	0	\$0	0	\$0	0	\$0	0	\$0	5	\$100,750	\$100,750
Project Mgmt	\$75,000	year	0.5	\$37,500	1	\$75,000	1	\$75,000	1	\$75,000	1	\$75,000	\$377,500

2. Commodities

Contraceptives

Condoms	\$49	1000	3000	\$147,000	3500	\$171,500	4000	\$196,000	4500	\$220,500	5000	\$245,000	\$980,000
IUDs	\$1	IUD	10000	\$10,000	12500	\$12,500	15000	\$15,000	17500	\$17,500	20000	\$20,000	\$75,000
IUD Kits	\$70	kit	59	\$4,130	75	\$5,250	75	\$5,250	75	\$5,250	75	\$5,250	\$25,130
Orals-Public	\$145	1000	200	\$29,000	250	\$36,250	300	\$43,500	350	\$50,750	400	\$58,000	\$217,500
Orals-Prvt	\$270	1000	0	\$0	100	\$27,000	200	\$54,000	300	\$81,000	400	\$108,000	\$270,000
Lab Equipment	\$1,000	lab	0	\$0	20	\$20,000	0	\$0	0	\$0	0	\$0	\$20,000
MCH Equipment	\$2,000	center	150	\$300,000	0	\$0	0	\$0	0	\$0	0	\$0	\$300,000
MCH Drugs	\$1,000	center	150	\$150,000	0	\$0	0	\$0	0	\$0	0	\$0	\$150,000
Vehicles	\$35,000	car	1	\$35,000	0	\$0	0	\$0	0	\$0	0	\$0	\$35,000
Freight		20%value		\$202,349		\$81,750		\$94,125		\$112,500		\$130,375	\$621,799

SUB-TOTAL USAID

	\$915,179	\$429,250	\$583,625	\$562,500	\$742,675	\$3,230,429
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INFLATION/CONTINGENCY

	\$0	\$64,581	\$144,427	\$194,617	\$197,626	\$600,350
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TOTAL PROJECT

	\$1,850,000	\$1,358,196	\$1,749,167	\$1,586,367	\$1,208,271	\$7,550,300
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REFORM COMPONENT

Training	\$250,000	1	\$250,000	0	\$0	0	\$0	0	\$0	0	\$0	\$250,000
Commodities	\$250,000	1	\$250,000	0	\$0	0	\$0	0	\$0	0	\$0	\$250,000

GRAND TOTAL

	\$2,150,000	\$1,358,196	\$1,749,167	\$1,586,367	\$1,208,271	\$8,050,000
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FAMILY HEALTH SUPPORT PROJECT
NOTES ON COST ESTIMATES

1. Technical Assistance: Short Term

From USA - Salary	\$225/day * 24 days	= \$ 5,400
Per Diem	\$190/day * 30 days	= \$ 5,700
Airfare	\$4000/trip	= \$ 4,000
Local Travel		= \$ 200
Miscellaneous		= \$ 200
		=====
Total		= \$15,500

From Lome- Salary	\$225/day * 24 days	= \$ 5,400
Per Diem	\$190/day * 30 days	= \$ 5,700
Airfare	\$1,000/trip	= \$ 1,000
Local Travel		= \$ 200
Miscellaneous		= \$ 200
		=====
Total		= \$12,500

Cameroon - Salary	\$190/day * 20 days	= \$ 3,800
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2. Training

Participant Expenses:

 Per Diem - \$69/day or \$52/day depending on the category of health provider.

 Travel - \$52/participant or \$17/participant, depending on the site for training.

 Materials - \$25/participant for all courses, except for \$300/participant for courses for clinical preceptors or with IUD, and \$600/participant for courses with Minilap training.

3. IEC Materials

From budget estimates for current JHU/PCS activities in Cameroon.

4. Contraceptives

Unit cost estimates according to guidelines from Commodities Division, ST/POP. Freight costs for air freight.

5. Host Country Contribution

The Government of the Republic of Cameroon (GRC) will make in-kind contributions minimally of US\$ 3,137,500 over the LOP, equal in value to 39 percent of USAID's contribution to the project. The value of the GRC's in-kind contribution was estimated as follows:

GRC's Budget for Health Sector (1990/1):	FCFA 22.75 billion
Percent Allocated to Salary Payments:	80%
Percent of MOPH PHC Staff in Provinces under the Project:	20%
Percent of Staff Time Allocated to Family Health Activities:	5%
FCFA 290 per US\$ 1.00	
	=====
Estimated Value of GRC In-kind Contribution per Year	US\$ 627,500
Estimated Value of GRC In-kind Contribution over LOP	US\$ 3,137,500

In addition, the GRC will provide in-kind contributions to the project in the form of: i) use of government training facilities, ii) use of service delivery sites, and iii) space at the Central Warehouse for ONAPHARM. The individuals and communities which will benefit from the family health services which will be promoted under this project will also contribute to the sustainability of these activities through user fee payments at private and public sector health institutions. A rough estimate of the cash payments to the PHC systems in the 4 provinces would be US\$ 4.0 million over the LOP, with a portion of this attributed to the provision of MCH-related services.

5. USAID Implementation Plan

The detailed implementation plans for each cooperating agency and for USAID are presented in the following tables.

CAMEROON NATIONAL FAMILY HEALTH PROGRAM - ILLUSTRATIVE IMPLEMENTATION PLAN

CONTRACTOR /AGENT	YEAR ONE	YEAR TWO	YEAR THREE	YEAR FOUR	YEAR FIVE
1. JIPIEGO -----					
* - TCA-16	* IN SERVICE TRAINING 3 3-WK CLINIC W/AUD DFM/SEATS 30 PM'S & HIGH RISK CENTERS	1 LAPAROSCOPY TRAINING COURSE AT CUSS FOR 6 OD/GYN'S FROM 3 PROVINCIAL HOSPITALS	CURRICULA REVISED AS NECESSARY		
UNDER FIII II			CURRICULA IMPLEMENTED IN NURSE/MIDWIFE & MEDICAL SCHOOLS		
	* 1 2-WK CURR DEV W/ CUSS: NEWBORNS, STDs, INFERTILITY, GYNECOLOGY	1 COURSE FOR 10 LAB TECHS IN STD DETECTION	1 COURSE FOR 10 LAB TECHS IN STD DETECTION		
	* 1 3 WK DIDACTIC & CLINIC TRNG W/AUD FOR NURSE/MIDWIFE SCHOOL FACULTY	PROCURE 3 LAPAROSCOPES			
		PROCURE MICROSCOPES, SLIDES, CULTURES, STAINS, AND OTHER SUPPLIES			
	* PROVISION OF EDUCATIONAL MATERIALS TO CUSS	NORPLANT TRIAL BEGINS UNDER CUSS SUBCONTRACT	NORPLANT TRIAL CONTINUED	NORPLANT TRIAL COMPLETED WITH REVIEW & EVALUATION	
		EVALUATION OF CURRICULUM			
	ST TA & MONITORING VISIT BY JIPIEGO HEADQUARTERS STAFF	ST TA & MONITORING VISIT BY JIPIEGO HEADQUARTERS STAFF	ST TA & MONITORING VISIT BY JIPIEGO HEADQUARTERS STAFF	ST TA & MONITORING VISIT BY JIPIEGO HEADQUARTERS STAFF	

II. PCS

**** - CAM 02
UNDER FIII II**

	YEAR ONE	YEAR TWO	YEAR THREE	YEAR FOUR	YEAR FIVE
	<p>**BASELINE KAP SURVEY</p> <p>** REPRINT OF LEAFLETS, POSTERS ALREADY DEV'D</p> <p>** DRAMA, VIDEO ON CHILD SURVIVAL/MATERNAL HEALTH</p> <p>DEV IEC TRAINING CURR: - COUNSELLING & INTERPERSONAL SKILLS - MOTIVATION TECHNIQUES</p> <p>1 TOT COURSE FOR 15 STAFF FROM CENTRAL, DEMU & PROVINCIAL HEALTH DEPTS</p>	<p>EVAL. OF MANUAL AND MATERIALS</p> <p>PROCURE IEC MATERIALS 1 TOT OF ANIMATEURS, EXT. WORKERS</p> <p>DEV OF STANDARDS & PROTOCOLS FOR ANIMATEURS & EXT WORKERS</p> <p>MATERIAL DEV: MCH, STD'S POSTERS, LEAFLETS</p> <p>DEVELOP 32 EPISODES OF RADIO SOAP OPERA</p> <p>DESIGN, TEST MOTIVATION RADIO MESSAGES & BEGIN BROADCASTS IN PROVINCES WHERE SERVICES AVAILABLE</p> <p>1 1-WK TRAINING OF 10 JOURNALISTS</p> <p>BEGIN MINI CAMPAIGNS FOR SPECIFIC TARGET GROUPS, E.G., POLITICAL & TRADIT LEADERS, YOUTH, MEN, WOMEN</p>	<p>REPRINT MATERIALS AS NECESSARY</p> <p>CONTINUE RADIO CAMPAIGNS AND REVISE AS NEEDED</p> <p>CONT. MINI CAMPAIGNS FOR SPECIFIC TARGET GROUPS, E.G., POLITICAL & TRADIT LEADERS, YOUTH, MEN, WOMEN</p>	<p>CONTINUE RADIO CAMPAIGNS AND REVISE AS NEEDED</p> <p>CONT. MINI CAMPAIGNS FOR SPECIFIC TARGET GROUPS, E.G., POLITICAL & TRADIT LEADERS, YOUTH, MEN, WOMEN</p>	<p>CONTINUE RADIO CAMPAIGNS AND REVISE AS NEEDED</p> <p>CONT. MINI CAMPAIGNS FOR SPECIFIC TARGET GROUPS, E.G., POLITICAL & TRADIT LEADERS, YOUTH, MEN, WOMEN</p>
	<p>DESIGN, PRE-TEST, & PRINTING OF IEC MANUALS, MATERIALS</p> <p>PROCURE IEC MATERIALS</p>				
	<p>ST & TA MONITORING VISIT BY PCS HEADQUARTERS STAFF</p>	<p>ST & TA MONITORING VISIT BY PCS HEADQUARTERS STAFF</p>	<p>ST & TA MONITORING VISIT BY PCS HEADQUARTERS STAFF</p>	<p>ST & TA MONITORING VISIT BY PCS HEADQUARTERS STAFF</p>	<p>ST & TA MONITORING VISIT BY PCS HEADQUARTERS STAFF</p>

	YEAR ONE	YEAR TWO	YEAR THREE	YEAR FOUR	YEAR FIVE
III. PAC II ----- # - FINANCED UNDER FIII II	* DEV CLINICAL STANDARDS & PROTOCOLS FOR MATERNAL HEALTH/CHILD SPACING * DEVELOPMENT OF FPMH IN SERVICE CURRICULUM * 2-3 WK TOT COURSES FOR 20 MOPII STAFF FROM CENTRAL & PROVINCIAL LEVELS * 2-3 WK COURSES FOR 20 PRECEPTORS FROM PROVINCIAL SITES CHOSEN FOR PRACTICUMS		1-3 WK TOT COURSE FOR 10 MOPII STAFF FROM CENTRAL & PROVINCIAL LEVELS 1-3 WK COURSE FOR PRECEPTORS FROM PROVINCIAL SITES		
	2-4 WK BASIC MCH/FP/STD COURSES FOR 40 PARTICS, WITH IUD INSERTION TRAINING IN WEEK 4. TA FOR 1 COURSE ONLY; LOCAL TRAINERS TO DO OTHER COURSES W/O EXTERNAL TA	2-4 WK BASIC MCH/FP/STD COURSES FOR 40 PARTICS, WITH IUD INSERTION TRAINING IN WEEK 4.	3-4 WK BASIC MCH/FP/STD COURSES FOR 60 PARTICS, WITH IUD INSERTION TRAINING IN WEEK 4.	2-4 WK BASIC MCH/FP/STD COURSES FOR 40 PARTICS, WITH IUD INSERTION TRAINING IN WEEK 4.	
	2-3 WK BASIC MCH/FP/STD COURSES FOR 40 PARTIC, W/O IUD TRAINING	2-3 WK BASIC MCH/FP/STD COURSES FOR 40 PARTICS, W/O IUD TRAINING 2-3 WK MCH/FP/STD UPDATE COURSES FOR 24 PARTICS, WITH IUD TRAINING IN WEEK 3 (EXTERNAL TA FOR FIRST COURSE ONLY)	3-3 WK BASIC MCH/FP/STD COURSES FOR 60 PARTICS, W/O IUD TRAINING 3-3 WK MCH/FP/STD UPDATE COURSES FOR 36 PARTICS, WITH IUD TRAINING IN WEEK 3 3-2 WEEK MCH/FP/STD UPDATE COURSES FOR 36 PARTICS, WITH IUD TRAINING	2-3 WK BASIC MCH/FP/STD COURSES FOR 40 PARTICS, W/O IUD TRAINING 4-3 WK MCH/FP/STD UPDATE COURSES FOR 48 PARTICS, WITH IUD TRAINING IN WEEK 3 5-2 WEEK MCH/FP/STD UPDATE COURSES FOR 100 PARTICS, W/O IUD TRAINING	
	SF TA & MONITORING VISIT BY INTRAI HEADQUARTERS STAFF	SF TA & MONITORING VISIT BY INTRAI HEADQUARTERS STAFF	SF TA & MONITORING VISIT BY INTRAI HEADQUARTERS STAFF	SF TA & MONITORING VISIT BY INTRAI HEADQUARTERS STAFF	

IV. SEATS	YEAR ONE	YEAR TWO	YEAR THREE	YEAR FOUR	YEAR FIVE
FUNDING SOURCE: APPROX 50% CENTRAL & 50% BILATERAL	* HIRING OF PUBLIC SECTOR RESIDENT ADVISOR	NEEDS ASSESSMENTS FOR PUBLIC SECTOR CLINICS IN 4 PROVINCES			
	* HIRING OF PRIVATE SECTOR RESIDENT ADVISOR * NEEDS ASSESSMENTS FOR PRIVATE SECTOR * SENSITIZATION TRAINING FOR PRIVATE PROVIDERS	INTEGRATION OF FP/MI SERVICES IN 40 PRIVATE SECTOR SITES SENSITIZATION TRAINING FOR PRIVATE SECTOR PROVIDERS	INTEGRATION OF FP/MI SERVICES IN 40 PRIVATE SECTOR SITES	INTEGRATION OF FP/MI SERVICES IN 35 PRIVATE SECTOR SITES	
	*SUPPORT FP/MI IN 30 PRIVATE CLINICS DESIGN OF FP/MI PROGRAM ANNUAL WORK PLAN	DESIGN OF FP/MI PROGRAM ANNUAL WORK PLAN SUPERVISION AND MANAGEMENT SUPPORT FOR PRIVATE SECTOR SERVICES SITES	DESIGN OF FP/MI PROGRAM ANNUAL WORK PLAN SUPERVISION AND MANAGEMENT SUPPORT FOR PRIVATE SECTOR SERVICE SITES	DESIGN OF FP/MI PROGRAM ANNUAL WORK PLAN SUPERVISION AND MANAGEMENT SUPPORT FOR PRIVATE SECTOR SERVICES SITES	
	1 2 WK TOT FOR 10 PARTICS	1 2 WK TOT FOR 10 PARTICS			
	4 3 WK CLINICAL TRAINING COURSES FOR 40 PARTICS	8 3 WK CLINICAL TRAINING COURSES FOR 80 PARTICS	10 3 WK CLINICAL TRAINING COURSES FOR 100 PARTICS	7 3 WK CLINICAL TRAINING COURSES FOR 70 PARTICS	
	3 8 DAY MINILAP TRAINING COURSES FOR 42 DRS. & NURSES	3 8 DAY MINILAP TRAINING COURSES FOR 42 DRS & NURSES	3 8 DAY MINILAP TRAINING COURSES FOR 42 DRS & NURSES	3 8 DAY MINILAP TRAINING COURSES FOR 42 DRS. & NURSES	3 8 DAY MINILAP TRAINING COURSES FOR 42 DRS & NURSES
	PROCURE 2 COMPUTERS/PRINTERS & SOFTWARE				
	4 MO. ST TA & SEATS MONITORING VISITS	4 MO. ST TA & SEATS MONITORING VISITS	2 MO. ST TA & SEATS MONITORING VISITS	2 MO. ST TA & SEATS MONITORING VISITS	2 MO. ST TA & SEATS MONITORING VISITS

	YEAR ONE	YEAR TWO	YEAR THREE	YEAR FOUR	YEAR FIVE
V. PSI *FUNDED FROM NON- BILATERAL SOURCES	<p>* SOCIAL MARKETING FIRMLY ESTABLISHED IN 4 NEW URBAN AREAS (FOR TOTAL OF 34 AREAS)</p> <p>* DEV ADVERTISING, POINT OF PURCHASE POSTERS, NOTICES FOR EACH PRODUCT</p>	<p>* SOCIAL MARKETING FIRMLY ESTABLISHED IN 5 NEW URBAN AREAS (FOR TOTAL OF 39 AREAS)</p>	<p>* SOCIAL MARKETING FIRMLY ESTABLISHED IN 6 NEW URBAN AREAS (FOR TOTAL OF 45 AREAS) IN CAMEROON</p> <p>* EVALUATION OF IMPACT OF SOCIAL MARKETING OF CONTRACEPTIVES ON INCREASED UTILIZATION OF CONTRACEPTIVES IN CAMEROON</p>		
	SOCIAL MARKETING: 30 MILLION CONDOMS	SOCIAL MARKETING: 35 MILLION CONDOMS	SOCIAL MARKETING: 4 MILLION CONDOMS	SOCIAL MARKETING: 45 MILLION CONDOMS	SOCIAL MARKETING: 5 MILLION CONDOMS
VI USAID	<p>PROCUREMENT OF CONTRACEPTIVES</p> <p>PREPARE PIO'S FOR COOPERATING AGENCIES AND LOCAL HIRE PSC</p> <p>SCHEDULE, COORDINATE & MONITOR ACTIVITIES OF COOPERATING AGENCIES WITH MOPH PARTICIPATING DIRECTORATES</p> <p>PROCURE MCH DRUGS, MCH EQUIPMENT, AND VEHICLE</p>	<p>PROCUREMENT OF CONTRACEPTIVES</p> <p>PREPARE PIO'S FOR COOPERATING AGENCIES</p> <p>SCHEDULE, COORDINATE & MONITOR ACTIVITIES OF COOPERATING AGENCIES WITH MOPH PARTICIPATING DIRECTORATES</p> <p>PROCURE MCH DRUGS, MCH EQUIPMENT AND LAB EQUIPMENT</p>	<p>PROCUREMENT OF CONTRACEPTIVES</p> <p>PREPARE PIO'S FOR COOPERATING AGENCIES</p> <p>SCHEDULE, COORDINATE & MONITOR ACTIVITIES OF COOPERATING AGENCIES WITH MOPH PARTICIPATING DIRECTORATES</p> <p>PREPARE SOW FOR AND OVERSEE MID TERM EVALUATION</p>	<p>PROCUREMENT OF CONTRACEPTIVES</p> <p>PREPARE PIO'S FOR COOPERATING AGENCIES</p> <p>SCHEDULE, COORDINATE & MONITOR ACTIVITIES OF COOPERATING AGENCIES WITH MOPH PARTICIPATING DIRECTORATES</p>	<p>PROCUREMENT OF CONTRACEPTIVES</p> <p>PREPARE PIO'S FOR COOPERATING AGENCIES</p> <p>SCHEDULE, COORDINATE & MONITOR ACTIVITIES OF COOPERATING AGENCIES WITH MOPH PARTICIPATING DIRECTORATES</p> <p>PREPARE SOW FOR AND OVERSEE FINAL EVALUATION</p>

**VII. PIC
COMPONENT**

YEAR ONE

**SIGNING OF LEGAL
TEXT ADOPTING
REORIENTED PIC
STRATEGY AS
MOPII POLICY**

**OFFICIAL ADOPTION
OF FPMH MEDICAL
STANDARDS**

YEAR TWO

**LAUNCHING OF
PIC ACTIVITIES
IN 33 NEW HEALTH AREAS**

YEAR THREE

YEAR FOUR

YEAR FIVE

6. USAID Management Plan

6. USAID Management Plan

A. USAID Responsibilities

USAID's Health, Nutrition, and Population (HNP) Office will have responsibility for the implementation of the project. The HNP Office will be assisted by a project committee composed of representatives of the USAID Program Office, Office of Project Development, Controller's Office, and the Contract Management Office.

USAID will be responsible for providing the following inputs: procurement of contraceptives and related supplies for the MOPH, the religious, parastatal and for-profit health clinics and the private sector condom social marketing program; procurement of services for evaluations; procurement of a personal services contractor as population program coordinator; and procurement of services from centrally funded cooperating agencies (CA). The USAID HNP Office will be responsible for monitoring the performance of the four cooperating agencies.

The proposed project structure will not increase greatly the management responsibilities of the mission beyond what it presently supports. In effect, this project will replace the Cameroon FHI-II subprojects. The project structure will reduce the total number of S&T/POP cooperating agencies in Cameroon from eight to four (SEATS, JHPIEGO, JHU/PCS and PAC II). Commodity procurement will increase over current levels and will be concentrated in the early years of the project. Contraceptives procurement will increase substantially each year, but procedures for this specialized procurement are well established with A.I.D./Washington.

B. Responsibilities of the Four Centrally Funded Cooperating Agencies

Each of the four cooperating agencies will be responsible for implementing its annual workplan which will be agreed to in advance by USAID, the MOPH, and the private sector organizations with which it will work. In summary, JHPIEGO will be responsible for pre-service training and Norplant trials; PAC II will be responsible for in-service training; JHU/PCS will be responsible for IEC; and SEATS will be responsible for expansion of child spacing services delivery in the private sector, mini-laparotomy training, logistics and services statistics development, and institutional strengthening of the MOPH's DFMH. Each CA will be responsible for collecting the data necessary to track project implementation progress and project impact. Each CA will maintain financial records, prepare vouchers for payment under its contract or cooperative agreement with A.I.D., and arrange for the financial assessment of firms or organizations providing services to the CA or receiving and disbursing funds on its behalf. The four CA's will be coordinated by the MOPH's DFMH in collaboration with the Population Program Coordinator. SEATS will provide long-term technical assistance to the DFMH in strategically planning the inputs not only from these four CA's but from the other donors active in the sector. As such, SEATS will serve as the lead A.I.D. cooperating agency involved in the implementation of the project.

C. Responsibilities of the GRC Implementing Agencies

The GRC implementing agency for this project is the Ministry of Public Health's Directorate of Family and Maternal Health. The DFMH will be responsible for overall project monitoring and management, will manage the proposed GRC inputs to the project, will coordinate with other

directorates of the MOPH to assure integration of project inputs into the ongoing PHC program, and will participate in the annual project reviews. The Project Description section of this Project Paper describes the different tasks of the MOPH directorates involved in the project and their interaction.

D. Responsibilities of the PHC Population Program Coordinator

Major duties will include the following:

1. Plan, coordinate, and monitor all activities under the Cameroon National Family Health Project including review of workplans and budgets; monitoring of project implementation through site visits and meetings; and review of progress, training, and financial reports.
2. Serve as liaison between the MOPH directorates responsible for project implementation (DFMH and DPRM), other ministries, and the four centrally funded cooperating agencies.
3. Review, coordinate, and monitor all other A.I.D. regional and centrally funded population activities in Cameroon and ensure that all activities fit into USAID's population strategy as outlined in the Project Paper.
4. Coordinate USAID's population program with those of other donors (UNFPA, World Bank, etc.).
5. Monitor contraceptive needs, prepare annual contraceptive procurement tables, prepare documents for annual procurement of contraceptives, and track all contraceptive commodities.

7. Summary of Project Analyses

A. Administrative Analysis

The four government offices responsible for different aspects of project implementation (DFMH, DPRM, CUSS, and Provincial Health teams) already work together on many different aspects of primary health care. Child spacing and maternal health activities will be integrated into ongoing PHC activities. The project direction will be in the DFMH, with the director being responsible for coordinating all activities on the government side. Under a buy-in to the SEATS project, a resident advisor will be assigned to advise on strategies and plans for integrating child spacing and maternal health into the PHC and to advise on coordination of all maternal health/child spacing activities within the MOPH and among donors. A resident advisor for the private sector will also be made available to provide technical assistance for expanding child spacing activities there.

All activities in the field will be under one administrative body, the Provincial Health Team. Based on guidance provided by the DFMH, these teams will devise plans to integrate child spacing and maternal health activities into their provinces. The donor agencies providing support for PHC in these provinces will assist in this effort. Once the provincial implementation plans are approved by the DFMH, the Provincial Health Teams will assure that elements of this plan are integrated into the annual health district plans. The teams will be responsible for the execution of these plans with the resources provided under the project.

With this assistance and with the short-term assistance for training and consulting which the USAID contractors will supply, the national implementing agencies will be able to properly administer and manage the interventions under this project.

B. Economic and Financial Analysis

The financial analysis examined the marginal recurrent costs of this project by studying the existing recurrent costs covered by the PHC system and identifying the additional burdens which will be imposed on the system. The project will introduce its activities within the PHC system; therefore, most costs associated with service delivery (supervision, logistics, management training) will already be financed through the PHC system (drug sales and consultation fees). The marginal recurrent costs of the project have been identified in the financial analysis and are minimal.

Since the project will be integrated within the PHC system, the financial viability of the project will depend on the sustainability of the PHC system. Therefore, an analysis of the financial viability of PHC system was conducted. Recurrent costs were identified and allocated to the appropriate funding group (MOPH, donors, community); underlying assumptions to the PHC system were identified; factors which could possibly jeopardize the basis of those assumptions were noted; and aspects in the design of the PHC system which strengthen the chances for sustainability were outlined.

Since the PHC system depends so heavily on community-based financing, the analysis also focused on the population's ability and willingness to pay for health care. It was noted that Cameroon has a much higher standard of living than most of its African neighbors and many people have demonstrated their demand for care by spending large amounts of money for health care in the private sector. However, due to the national economic crisis which is now entering its third year,

people have significantly less disposable income. As a result, health facility utilization (in public, religious, and private sectors) has declined dramatically since 1988 and particularly since 1989. The PHC system is designed to be sustainable by reducing reliance on the central government to a minimum; however, until the economic crisis lessens, the population may initially have a difficult time supporting all the more ambitious elements of the cost recovery system (i.e., the full range of in-service training and depreciation of motorcycles). The MOPH appears sensitive to this and will be trying to reduce ambitious cost recovery targets by scaling down certain activities or increasing donor commitments during this time of economic hardship.

The project will invest in the religious and private sectors. The religious sector will continue to cover its recurrent costs in the same way it has traditionally operated, that is, through a combination of community financing and outside donations from their overseas parishes. The private sector will support its recurrent costs by passing them on to the patient.

The future viability of the Cameroon Condom Social Marketing Program (CCSMP) was analyzed by projecting costs and revenues under three different sales volume scenarios. Under the worst-case scenario of 15 percent annual sales growth projections on their three products, condoms, oral contraceptives and oral rehydration salts, the CCSMP would continue reliance on donors for commodities (all products) and operating funding. Under the mid-case (20 percent annual sales growth) and the best-case scenarios (25 percent annual sales growth), the CCSMP would increasingly reduce its dependence on donors for both commodities and operating funds. (Although CCSMP is aggressively seeking ways to increase sales volume, future sales volumes are difficult to predict in untested markets during a period of macro-economic decline.)

The PHC system is based on a system of decentralized health care delivery and community co-financing and co-management (referred to as "co-financed" centers). Health centers charge patients a 200 FCFA consultation charge and a fee for drugs which is the wholesale price plus a mark-up of approximately 160 percent. This mark-up was calculated so as to ensure the sustainability of several key components to a well-functioning PHC system (e.g., regular supervision from the provincial and district levels, regularly paid pharmacy clerks, gasoline for motorcycle outreach activities, refresher training, transportation costs to district depots to restock drugs, functioning of district depots, etc.). Much effort has already gone into developing financial control systems, supply/distribution networks, and into logistics and financial management training for the health center pharmacy clerks, depot clerks, health facility staff, and supervisors. This system began in 18 health facilities in Adamaoua and South Provinces in January 1991; by the end of 1993, approximately 95 health facilities in each of the two provinces will be co-financed. A similar effort is under way in the Extreme North and Centre provinces.

The establishment of a pricing policy for contraceptives is difficult in an environment with uncertain demand for modern contraceptive methods. Since private sector institutions will be required to purchase contraceptives after the initial stock is provided by USAID, it is assumed that these institutions will be required to price the commodities at close to their full cost. On the other hand, government institutions will receive contraceptives without charge over the LOP, and thus can more readily provide methods at prices lower than full cost to the lower income groups in the population. Given the significant externalities associated with child spacing and the reduction in the number of unwanted children, no potential contraceptive user should be refused access to a contraceptive method due to an inability to pay. A pricing policy for contraceptives, as for drugs, should give attention to issues of variation in income and ability to pay throughout the country. Consideration should also be given to the development of contraceptive pricing policies that encourage the adoption

of more effective methods (e.g., IUDs instead of condoms). When the national child spacing program is well established throughout the country (sometime following the project), contraceptives will be sold in the public sector at their full replacement cost.

C. Technical Analysis

The principal question of relevance to analysis of the technical soundness of the project concerns the safety and efficacy of the family health interventions proposed for inclusion in this project when supplied in the context of the Cameroonian setting. Although the theoretical method effectiveness for modern contraceptives is over 90 percent for most methods, the overall contraceptive impact of the project will be low if Cameroonian women do not adopt an appropriate method and continue its use. A study in Cameroon by JHU/PCS found that incomplete and incorrect information about the benefits of modern methods of family planning was widespread among focus group respondents. However, health providers were identified as the most credible source of information about family planning, and the authors proposed that mass media would be a good vehicle for stimulating discussion of family planning in the population. Project activities to 1) provide pre-service and in-service training about family planning methods and communication skills to health providers in both the public and private sectors, and 2) develop and support IEC activities through a number of channels, including the mass media, are congruent with the objective of improving maternal health through adoption of family planning to improve child spacing.

Training activities of the project have been designed in recognition of the fact that different levels of health providers will be competent to provide a greater mix of contraceptive methods. IUD training will be provided to only half of the non-MD personnel. Minilap and laparoscope training will be provided only to individuals who work in centers with the appropriate facilities and back-up for these procedures. Refresher training will be provided to all non-MD personnel trained by the project. Training will include information regarding the benefits and contraindications regarding each method.

To the extent that STDs are associated with infertility, project activities aimed at early STD detection, and provision of counselling regarding the relationship of method choice to STDs, would be expected to reduce the incidence of infertility.

D. Social Soundness Analysis

The social organization of Cameroon is characterized by its diversity. There are approximately 200 distinct ethnic groups, each with its own language and social organization. Fertility is highly valued in Cameroonian society, and proof of a woman's fertility is traditionally required in some groups before a woman can be married. Polygamy is common: 22 percent of men, and 38 percent of married women are polygamous. Divorce is also common, with 74 percent of divorces requested by women reportedly due to mistreatment by husbands. Infertility is also a significant problem, with about 25 percent of women at risk of infertility.

Achievement of the objectives of this project will be facilitated by several trends in the socio-cultural setting in Cameroon. Specifically, the economic crisis and rapid urbanization of the population are making adoption of a population policy and development of family planning services more acceptable to political and social groups. The integration of child spacing into maternal and child health services

by health workers underlines to patients the importance of the former in assuring maternal and child health. Concerns on the part of the population with infertility will be addressed by the project, and thereby make family planning more credible.

After decades of being a pro-natalist country, the Government of Cameroon will soon adopt a national population policy that advances the strategy of "responsible parenthood." This means that parents should plan and be responsible for their families within the level of their resources and in view of their hopes and beliefs. At the same time, there remain some pro-natalist financial incentives within the government structure, such as monthly payments for children to the limited number of people enrolled in the social security system.

Men, important in contraceptive decision-making, will be targeted for IEC campaigns under the project. Women, regardless of age and social status, already are expressing a high demand for reducing the number of children they bear, although many are ignorant of modern methods of family planning. Given that 57 percent of women give birth at a health clinic, maternity, or hospital, health providers can serve as an important source of family planning information. By making quality services available in more clinics, public and private, for a reasonable price, and informing people of their availability, more couples will have access to family health services.

Project beneficiaries will include 1) women provided with child spacing, infertility, and other family health services; 2) service providers in the public and private sectors; and 3) organizations within the public and private sector which receive technical assistance, training, or commodities with which to provide quality family health services.

8. Conditions Precedent to Disbursement

A. Conditions to First Disbursement

Prior to the first disbursement under the grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the grantee will, except as the parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

- (a) A statement of the name of the person holding or acting in the office of the grantee specified in Section 8.2., and of any additional representatives, together with a specimen signature of each person specified in such statement;
- (b) Evidence that the grantee has constituted a project technical committee comprised of members drawn from the Directorate of Preventative Medicine, the Directorate of Family and Mental Health, the University Center of Health Sciences, and other appropriate offices.

B. Conditions Precedent for Policy Reform Component

Prior to the disbursement of funds under the policy reform component of the project, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the grantee will provide, in form and substance satisfactory to A.I.D., evidence that the following actions have been completed:

- (a) Promulgation of "an arrete ministeriel" signed by the Ministry of Public Health declaring the reorientation of primary health care based upon the principles of community co-management, community co-financing, the availability of essential drugs, and integrated service delivery as official national health policy; and
- (b) Adoption of a "note de service" by the Minister of Public Health that clearly defines the service delivery policy and medical standards required for the integration of child spacing/maternal activities into the primary health care program.

9. Monitoring and Evaluation Plan

9. Monitoring and Evaluation Plan

A. Monitoring Plan

Monitoring activities will track and assess progress of project implementation of all components and will provide the baseline data required to monitor and evaluate the achievement of project benchmarks and eventually the people-level impact.

Implementation Monitoring

USAID will monitor the National Family Health Project to track progress for the following activities:

- fulfillment of the conditions precedent to project start-up;
 - contracting with the four cooperating agencies through buy-ins to centrally funded A.I.D./Washington projects;
 - contraceptive procurement by USAID;
 - provision of all A.I.D. inputs;
 - provision of financial and in-kind inputs of the GRC;
 - performance of the four cooperating agencies;
 - performance of the recipients of project inputs, including the MOPH, religious, parastatal and for-profit health clinics and the condom social marketing program.
- a. The project benchmarks are
- 1) increased number of child spacing/maternal health providers as measured by
 - number of new private sector health personnel trained in child spacing/maternal health service delivery and contraceptive methods (target 455);
 - number of public sector health personnel trained in child spacing/maternal health service delivery and contraceptive methods (target 819); and
 - number of functional public and private sector health facilities delivering child spacing/maternal health interventions (baseline 40; target 308).
 - 2) increased availability of child spacing contraceptives and supplies as measured by
 - contraceptive sales through public sector health clinics and religious, parastatal and for-profit private sector health facilities measured by couple years of protection (baseline 30,000 CYP; target 120,000 CYP);
 - number of sites where contraceptives are sold (baseline 40; target 308);
 - number of contraceptives distributors including public sector, religious, parastatal and for-profit clinics in the private sector and through the condom social marketing program (baseline approximately 200; target 1500);
 - analysis of contraceptive method mix (baseline to be determined by 1991 DHS survey);
 - sales volume through the condom social marketing program (baseline 2.1 million; target 4.5 million); and

- 3) increased availability of information on child spacing/maternal health as measured by
- number of women of reproductive age aware of child spacing and contraceptive methods (baseline to be determined by 1991 DHS survey);
 - number of men aware of child spacing and contraceptive methods (baseline to be determined by 1991 DHS survey); and
 - number of locations where child spacing/maternal health information is available, including television, radio, newspapers, pharmacies and public and private sector health facilities (baseline less than 50; target 500).

Data on the number of trainees and the number of functional facilities will be provided by the four cooperating agencies. Data on contraceptive sales, distribution points, and couple years of protection will come from the DFMH's contraceptive warehouse and from the PSI condom social marketing program. Data on IEC indicators will come from periodic facility and community-based surveys conducted under the JHU/PCS buy-in. Regarding purpose-level indicators, the demographic and health surveys of 1991 and 1996 will provide data on contraceptive prevalence, infant and child mortality, and population-based information on knowledge, attitudes, and practices of modern contraceptives.

Monitoring Responsibilities

Monitoring is the responsibility of USAID and the GRC, especially the MOPH, the four cooperating agencies, the agency managing the condom social marketing program and the religious, and the parastatal and for-profit health clinics of the private sector.

USAID through its HNP Office and the GRC through the DFMH will have responsibility for coordination of overall monitoring to ensure the entire program is implemented according to the agreements between USAID and the GRC. USAID's HNP Office will be responsible for tracking project benchmarks through reports received from the MOPH, the cooperating agencies, the PHC donors active in the four project provinces, and through special analyses, surveys and evaluations.

B. Evaluation Plan

The evaluation component of the National Family Health Project will be managed directly by USAID. All evaluation activities will be carried out with the full collaboration of the GRC, including the public and private sector institutions which will participate in the project. Annual in-house evaluations to assess progress and problems will begin one year after the signing of the first project agreement. Two external evaluations are proposed during the life of the project.

Monitoring activities will provide the baseline data for both the mid-term and final project evaluations.

Proposed Evaluation Schedule

12 months	First annual multi-participant review
24 months	Annual review

30 months	Mid-term external evaluation, with recommendations for any significant modifications to project design
36 months	Annual review
48 months	Annual review
54 months	Final evaluation including impact assessment

The mid-term evaluation is planned about 30 months after the signing of the project agreement. This evaluation will review

- management of inputs;
- status of outputs;
- progress in attaining purpose-level objectives;
- define any management changes required for timely fulfillment of project objectives;
- status of project and policy benchmarks;
- adequacy of benchmarks and indicators for assessing overall impact at final evaluation and making recommendations for modifications in baseline monitoring, if required;
- technical assistance requirements and progress by the four cooperating agencies in imparting technical and management skills to Cameroonian counterparts to enable them to assume an increasingly greater role in project implementation;
- continuing relevance of the project given changes in the political and socio-economic environment of Cameroon; and
- progress toward sustainability.

The final evaluation is planned for about 6 months before program completion. This evaluation will include

- review of the extent to which project and policy benchmarks have been achieved;
- review of progress made in attaining purpose-level objectives and the progress of project components in realizing input and output targets;
- assessment of impact on beneficiaries due to increasing numbers of service providers, availability and accessibility of supplies, and increased information;
- assessment of the project success in achieving sustainability;
- assessment of both the attainment and potential for attainment of goal-level objectives; and
- provide recommendations regarding future USAID assistance for child spacing and maternal health.

10. Procurement Plan

10. Procurement Plan

A. Overview

The project is 100 percent financed from the Development Fund for Africa (DFA) appropriations account. All procurement will be conducted following the procurement guidelines for activities financed under the DFA. Accordingly and to the extent practicable, the project will utilize goods and services of U.S. origin and from U.S. sources. All vehicles, due to the local availability of parts and maintenance shops, will be procured from Code 935 sources as allowed by the DFA legislation. All training will be conducted locally, except for several short-term observation visits to other African countries with advanced family planning programs. Procurement of computer equipment and software may be from other free world sources and will be of U.S. origin. USAID/Cameroon, with the assistance of A.I.D./Washington's Office of Transportation (SER/OP/TRANS) will make every effort to ensure that commodities procured directly by A.I.D. or through A.I.D. contractors will be shipped on U.S. flag carriers in compliance with the U.S. Cargo Preference Act. The USAID Contracting Office will maintain records of all project procurement by A.I.D. Geographic Code and will report this information annually to A.I.D./Washington's Africa Bureau Office of Project Development. With the development of the procurement plan in accordance with Africa Bureau guidelines, USAID/Cameroon is maximizing U.S. procurement to the extent possible.

B. Responsibilities

USAID/Cameroon will procure the services of four cooperating agencies, John Snow, Inc., JHU/PCS, JHPIEGO, and INTRAH, through established buy-in procedures to worldwide contracts or cooperative agreements managed by S&T/POP as well as a local-hire personal services contractor to assist in project administration and management. A.I.D./Washington, through its Commodities and Program Support Division (CPSD) will purchase all forms of contraceptives. The cooperating agencies will purchase supplies and selected other commodities related to their scopes of work. This includes procurement of one vehicle, computers and software, IEC supplies, long- and short-term local and expatriate technical assistance and management of local contracts and costs related to local training. USAID will procure essential maternal health drugs and health center equipment.

C. Procurement Plan

The procurement plan described below shows the anticipated sources and origins of the project's technical services and commodities. The list of services and commodities is ordered according to the project implementation responsibility areas. The Procurement Plan Table is included as Annex G.

Procurement of Technical Services

USAID will procure the services of four cooperating agencies through buy-ins to worldwide contracts or cooperative agreements managed by A.I.D./Washington's S&T/POP. It was determined that use of the buy-in mechanism offered substantial cost savings to the Mission compared to procuring equivalent services through a competitive bidding process. The main reason is that many of the overhead costs of the buy-in contracts and grants are borne by core funding from S&T/POP. These costs would be borne by the Mission in the case of a competitively bid contract under the bilateral

project. It is likely that even if the Mission had determined to seek a contractor to manage most of the bilateral activities, the Mission would also utilize the specialized services of these four cooperating agencies for some activities.

These centrally funded cooperating agencies have already been selected on the basis of competitive bidding or sole source selection, and they are already working in Cameroon with funding from USAID/Cameroon under the FHI II Project. Each of the agencies will sign Memoranda of Understanding with the GRC specifying roles, responsibilities, and resource contributions in executing their activities. The Memoranda of Understanding must be approved by USAID prior to submission to the GRC for approval.

Procurement of Commodities

USAID will procure all contraceptives and maternal health drugs through the established procedures of A.I.D./Washington. USAID will directly procure essential maternal health clinic equipment from U.S. suppliers.

Since contraceptives represent about 20 percent of the total budget and are such an important element of the project, the system for procurement, clearance, and distribution of contraceptives deserves careful attention.

Logistics systems for the importation, storage, and distribution of contraceptives to public and private sector health services delivery institutions are fragmented. For example, UNFPA injectables are distributed from the PMI Centrale in Yaounde, IPPF contraceptives and related equipment are distributed to select projects by CAMNAFAW (an organization set up by IPPF), USAID's initial stock of contraceptives have been stored at an ONAPHARM warehouse, and HOSPICAM/PSI has undertaken port clearance, storage, packaging, and distribution of the social marketing condoms.

Under the Cameroon National Family Health project, USAID/Cameroon will order and purchase the contraceptives financed under the project. Although the specifics of procedures for distribution of the commodities remain to be clarified, the following describes what is expected to be the administrative arrangements for distribution of the commodities within Cameroon. The MOPH, with technical assistance and project funding from SEATS, will clear all contraceptives for public sector institutions through customs at the Yaounde or Douala airports. These contraceptives will be stored at the central warehouse of ONAPHARM in Yaounde. Provincial health teams will pick up contraceptives from the warehouse at the same time they replenish stocks of other medicines. Distribution to government health institutions within the province will follow the same procedures as for other medicines. Over the LOP, USAID contraceptives will be provided to government health institutions without charge. The initial stock of contraceptives for private sector institutions will also be placed in and distributed from the ONAPHARM warehouse. After the first year of stock, private sector institutions will be required to purchase contraceptive supplies from wholesalers in the private sector, e.g. Ad Lucem or HOSPICAM. Contraceptives and other products for the social marketing program will continue to be directly shipped to HOSPICAM, which will be responsible for port clearance, warehousing, packaging, and distribution.

USAID will organize a procurement seminar to train MOPH personnel to clear commodities from air and sea ports in a timely manner. Each cooperating agency will submit a regular list of purchases which will be consolidated into a master inventory record. USAID will maintain a master inventory record of all commodities imported and purchased locally under the project.

Training

All training will be done within Cameroon, except for observation-study tours, and will be organized and funded by the institutional contractors. The exact locations of in-service and pre-service training courses, seminars, and workshops will be identified by each institutional contractor as part of its annual work plan which will be reviewed and approved by USAID and the GRC.

Participation of Gray Amendment Firms

USAID will attempt to utilize Gray Amendment suppliers for the procurement of maternal health clinic equipment. Regarding the cooperating agencies, all have been pre-selected by A.I.D./Washington as described above. It should be noted that Gray Amendment considerations were included in the original selection of these centrally funded S&T/POP contractors.

Annexes

Annex A

PID/PAIP Approval Message

PID/PAIP Approval Message

AID2 AMB DCM (4)

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INFO RUEHAB/AMEMBASSY ABLEJAN 7555
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RECEIVED
USAID YAOUNDE
JUN 17 5 20 PM '91

LOC: 193 325
12 JUN 91 1159
CN: 14320
CHRG: AID
DIST: AIDA

ACTION: EHRD/HNF DUE 6/1
INFO: DIR
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EHRD
PRM
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E.O. 12356: N/A

TAGS:

SUBJECT: CAMEROON PROPOSED HEALTH/POPULATION ACTIVITIES;
FAMILY HEALTH SUPPORT PROJECT (FHS), 331-3084, AND PRIMARY
HEALTH CARE SUB-SECTOR REFORM PROGRAM (PHC), 331-2087.

1. A COMBINED ECPR FOR THE SUBJECT ACTIVITIES MET ON MARCH 11, 1991 TO REVIEW THE FINDINGS AND RECOMMENDATIONS OF THE PROJECT COMMITTEE ISSUES MEETINGS FOR THE TWO PROPOSED HEALTH/POPULATION ACTIVITIES FOR CAMEROON. THE MEETING WAS CHAIRED BY THE DIRECTOR OF AFR/PO AND INCLUDED REPRESENTATIVES FROM AFR/FE, AFR/CCWA, AFR/DP, AFR/FR, GC/AFR, ST/POP, ST/H, AND USAID/CAMEROON. THE ECPR RECOMMENDED THAT THE FHS PROJECT, AT A LEVEL OF DOLS 7,550,00 BE FORWARDED TO THE AA/AFR FOR APPROVAL. HOWEVER, THE PAIP WAS NOT APPROVED GIVEN NOTIFICATION BY USAID/CAMEROON THAT THERE WAS NO AVAILABLE FUNDING IN FY91 OR FY92 TO FUND WFA COMPONENT AND THEREFORE MISSION WISHED TO DEFER WFA AND PROCEED WITH ONLY THE PROJECT AT THIS TIME. BY AUTHORIZATION OF THIS CABLE, THE AA/AFR ACCEPTS THE ECPR RECOMMENDATION AND APPROVES THE PID, AT A LEVEL OF DOLS 7,550,000 (SUBJECT TO GUIDANCE PROVIDED BELOW) AND DELEGATES AUTHORITY TO THE MISSION TO APPROVE THE PF AND AUTHORIZE THE PROJECT IN THE FIELD.

2. THE FOLLOWING GUIDANCE IS PROVIDED FOR PF DEVELOPMENT.

GENERAL COMMENTS:

THE ECPR FOUND THAT THE MISSION DECISION OF INTERVENTION FOR THE PROPOSED ACTIVITIES WAS BASED ON A WELL UNDERSTOOD POLICY FRAMEWORK (MACRO, SECTORAL) AS WELL AS THE LESSONS LEARNED OVER THE LAST TEN YEARS OF USAID'S INVOLVEMENT IN THE HEALTH SECTOR. THE INTERVENTIONS DIRECTLY SUPPORT USAID'S CESS AND THE NEW STRATEGY TO PROMOTE COMMUNITY CO-FINANCED AND CO-MANAGED PRIMARY HEALTH CARE BASED ON FULL INTEGRATION OF SERVICES. GOVERNMENT OF CAMEROON'S SECTOR DEVELOPMENT OF ACTIVITIES IN THE SECTOR. THE ECPR MEMBERS RECOGNIZED THAT THE PIP REPRESENTS USAID/CAMEROON'S JOINT EFFORTS TO SUPPORT A BILATERAL POPULATION PROJECT AND THAT THAT THE MISSION SHOULD BE COMPLETING FOR THE HIGH QUALITY WORK WHICH SET DOWN INTO THE ANALYSIS AND DOCUMENT PREPARATION. THE ECPR ENCOURAGED THE MISSION TO CONTINUE

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TO PURSUE (AND EXPAND WHERE POSSIBLE) EFFORTS, THROUGH BOTH PROJECT AND NON PROJECT ASSISTANCE, IN THE HEALTH AND POPULATION SECTOR.

SPECIFIC COMMENTS:

A. COMPLEMENTARITY-LINKAGE/SUSTAINABILITY

THE ECPR NOTED THAT THE TWO SEPARATELY-PROPOSED HEALTH INTERVENTIONS (PA AND NPA) APPEAR TO BE SO COMPLEMENTARY THAT COMBINING AND DESIGNING PROJECT AND NPA COMPONENTS UNDER ONE ACTIVITY WOULD PERMIT THE ACHIEVEMENT OF GREATER DEVELOPMENT OBJECTIVES AND SUSTAINABILITY. INDEED, THE ECPR WAS CONCERNED THAT THE POLICY FRAMEWORK ANALYSIS AND THE RELATED REFORMS PROPOSED IN THE PAIP WERE SO CLOSELY TIED TO THE SUCCESSFUL ATTAINMENT OF SUSTAINABLE OBJECTIVES OF THE PROPOSED BILATERAL POPULATION PROJECT THAT THE TWO ACTIVITIES SHOULD BE DESIGNED AND IMPLEMENTED AS A COMBINED PA/NPA ACTIVITY. THE QUESTION OF DEPENDENCY VERSUS ENHANCEMENT WAS REVIEWED FOR THE TWO ACTIVITIES. THE USAID/CAMEROON REPRESENTATIVE NOTED THAT THE NPA REFORMS WERE IMPORTANT AND CLEARLY ENHANCED THE FAMILY PLANNING SUPPORT PROJECT (AS WELL AS OTHER ACTIVITIES IN THE MISSION HEALTH PORTFOLIO) BUT WERE NOT CONSIDERED CRITICAL TO OBTAINING THE PROJECT OBJECTIVES. HOWEVER, THE MISSION REPRESENTATIVE INDICATED THAT IF FUNDING HAD NOT BEEN AN ISSUE, THE ACTIVITIES WOULD HAVE BEEN DESIGNED TOGETHER FOR COMPLEMENTARITY AND MANAGEMENT REASONS. THE ECPR, AGREEING WITH MISSION REPRESENTATIVE OBSERVATIONS, RECOGNIZED THAT THE TWO ACTIVITIES COULD STAND ON THEIR OWN AND THEREFORE COULD BE DESIGNED SEPARATELY OR

TOGETHER, IN ACCORDANCE WITH THE MISSIONS BEST JUDGMENT.

THE ECPR ALSO EXAMINED THE SUSTAINABILITY ISSUE IN LIGHT OF THE RELATIVELY CONSERVATIVE NPA REFORMS PROPOSED IN THE PAIP AND QUESTIONED IF BROADER, MORE AGGRESSIVE REFORMS IN THE HEALTH SECTOR SHOULD BE SOUGHT (I.E., SEEKING ADEQUATE/SUFFICIENT GRC BUDGETARY ALLOCATIONS). THE ECPR CONCLUDED THAT THE PROPOSED NPA REFORMS ADEQUATELY ADDRESSED THE ISSUES WHICH WOULD LEAD TO A SUSTAINABLE COMMUNITY MANAGED HEALTH SYSTEM. THE ECPR NOTED THAT THE LARGER ISSUE OF GR BUDGET ALLOCATION REFORM WOULD HAVE TO BE ADDRESSED FROM A GOVERNMENT-WIDE EXPENDITURE BASIS (A COMPLEX AND LENGTHY EXERCISE) WHICH IS BEYOND THE SCOPE OF THIS INTERVENTION. HOWEVER, THE ECPR ENCOURAGES THE DESIGN TEAM TO EXAMINE THE POSSIBILITIES FOR BROADER REFORMS IN THE HEALTH SECTOR WHICH COULD BE ADDRESSED IN A SEPARATE LARGER NPA PROJECT AT A LATER DATE.

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B. FUNDING:

RELATED TO THE LINKAGE ISSUE IS THE PROBLEM OF AVAILABLE FUNDING. THE USAID/CAMEROON REPRESENTATIVE REPORTED THAT THERE WAS NOT SUFFICIENT OYB TO FUND THE NPA COMPONENT IN FY 91. THE ECPR FELT THAT IF ONLY THE PROJECT ELEMENT IS AFFORDABLE, AND CAN STAND ALONE WITHOUT NPA AS NOTED ABOVE, THEN THE MISSION'S ONLY CHOICE IS TO PROCEED WITH THE PROJECT ACTIVITY AT THIS TIME SINCE AID/W WILL BE UNABLE TO INCREASE USAID/CAMEROON OYB LEVEL. AS FOR FY 92 FUNDING AVAILABILITY, THE ECPR RECOMMENDED THAT MISSION SHOULD BE PREPARED TO REEXAMINE ITS PRESENT AND PLANNED PRIORITIES WITH AN EYE TO INCORPORATING AN NPA HEALTH PROGRAM, IF FOUND APPROPRIATE.

3. OTHER CONCERNS

BUY-INS: THE FES PROJECT WILL UTILIZE SEVERAL ST/POP CENTRALLY FUNDED PROJECTS. THE PACS OF TWO OF THESE ST/POP PROJECTS WHICH THE PROJECT WILL USE WILL END PRIOR TO THE FES PACD. HOWEVER, THE ST/POP REPRESENTATIVE ASSURED THE ECPR THAT THESE CENTRALLY-FUNDED PROJECTS WERE HIGH PRIORITY PROGRAMS WHICH WOULD BE CONTINUED UNDER FOLLOW-ON OR NEW PROJECTS. ADDITIONALLY, BE ADVISED THAT MISSION FUNDING FOR ST/POP PROJECTS CAN BE PROCESSED THROUGH OYB TRANSFERS INSTEAD OF BUY-INS (I.E. PIC/T). THIS WILL REQUIRE ST/POP TO AMEND CURRENT PROJECT AUTHORIZATIONS TO ALLOW FOR DPA FUNDING. THESE AMENDMENTS ARE IN PROCESS AND ST/POP HAS ASSURED AFR/PC THAT AMENDMENTS WILL BE COMPLETED BY JUNE 30, 1991. BE SHOULD CONTAIN RECONFIRMATION THAT ST/POP PROJECTS WILL BE

AVAILABLE AS REQUIRED FOR SUCCESS OF FES PROJECT.

INDICATORS: THE ECPR RECOMMENDED THAT THE PP DESIGN TEAM DEVELOP SYSTEMS AND QUANTIFIABLE INDICATORS TO EVALUATE THE CONTRACTIVE METHOD MIX AND PROGRAM IMPACT.

WID: THE ECPR NOTED THAT THE FES PID DID NOT ADDRESS WID CONCERNS. THE DESIGN TEAM SHOULD DEVOTE ADEQUATE ATTENTION TO GENDER CONSIDERATIONS AND SHOULD REFER TO SS STATE 20898 FOR DETAILED GUIDANCE REGARDING WHAT MUST BE COVERED IN THE PP/PAAD.

NATIONAL POPULATION POLICY: THE ECPR WAS ADVISED THAT CAMEROON HAS DEVELOPED A DRAFT NATIONAL POPULATION POLICY. THE POLICY HAS BEEN DISCUSSED AT REGIONAL SEMINARS AND WILL BE REVIEWED/FINALIZED IN MARCH BY THE NATIONAL POPULATION COMMISSION. OFFICIAL ADOPTION (BY THE PRESIDENT) IS EXPECTED IN MID-1991. THE ECPR RECOMMENDED THAT THE PP DESIGN INCLUDE A REVIEW/ANALYSIS OF THE POLICY IN THE PP.

GRAY AMENDMENTS: THE ECPR WAS COGNIZANT OF USAID/CAMEROON'S PAST EFFORTS TO UTILIZE, WHEREVER

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POSSIBLE, DISADVANTAGED ENTERPRISES IN DESIGNING AND IMPLEMENTING PROJECTS AND PROGRAMS. IN THIS RESPECT, THE ECPR WOULD ANTICIPATE USAID/CAMEROON WILL, TO THE EXTENT PRACTICABLE, UTILIZE DISADVANTAGED ENTERPRISES WHICH ARE CONTRACTUALLY ACCESSIBLE THROUGH A BUY-IN PROVISION UNDER REGIONAL OR CENTRAL HEALTH AND POPULATION PROJECTS.

AUTHORIZATION VENUE: THE ECPR RECOMMENDS THAT THE PP FOR THE CAMEROON HEALTH SUPPORT PROJECT BE APPROVED AND AUTHORIZED BY USAID/CAMEROON. EAGLEBURGER

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Annex B
Logframe Matrix

NATIONAL FAMILY HEALTH PROJECT LOGFRAME

NARRATIVE SUMMARIES

OBJECTIVELY VERIFIABLE INDICATORS

MEANS OF VERIFICATION

ASSUMPTIONS

PROJECT GOAL

To improve the health of Cameroonian women, infants and children.

Reduced mortality and morbidity rates for women, infants and children.

Demographic and Health Surveys in 1991 and 1996.

Continued political stability.

Reduced fertility rates for women.

National Population Census in 1997.

Current economic crisis does worsen significantly.

PROJECT PURPOSE

To integrate quality child spacing and maternal health services into the national primary health care program in 4 provinces and to expand the availability of these services through religious, para-statal, and private for-profit sector facilities.

Target population knowledgeable in child spacing/maternal health.

GRC statistics
Demographic and Health Surveys
Survey reports
Clinic records
Project evaluations

Policy makers continue to support revised PHC strategy and the integration of child spacing/maternal health services.

Clinics using service standards and protocols.

Child spacing/maternal health widely available in 163 public and 145 private health clinics.

Community co-managed and co-financed drug stores will significantly improve the quality of services.

OFMI effectively planning the nationwide expansion of child spacing/maternal health services.

Utilization of facilities will increase significantly as a result of improved quality of care, availability of essential drugs, and integrated PHC services.

Condoms readily available for sale to target population.

Contraceptive prevalence with modern methods increased from 23 to 7% of married women of reproductive age.

NATIONAL FAMILY HEALTH PROJECT LOGFRAME

<u>NARRATIVE SUMMARIES</u>	<u>OBJECTIVELY VERIFIABLE INDICATORS</u>	<u>MEANS OF VERIFICATION</u>	<u>ASSUMPTIONS</u>
PROJECT OUTPUTS			
Service providers trained in reproductive health.	819 public sector and 455 private sector health personnel trained.	Training records	Existing socio-cultural beliefs can be overcome or modified.
IEC program designed and implemented successfully.	Child spacing/maternal health materials and information widely distributed.	KAP surveys Materials collected Site visits Clinic records	Funds generated from cost recovery mechanisms and existing financial resources will be sufficient to finance PIC supervision, outreach and other variable operating costs.
Clinic and management standards and procedures tested, developed, adopted and implemented.	Protocols, procedures, and manuals designed and training conducted.	Training records Inspections, evaluations, and project implementation reports.	Expansion of sites with trained personnel, equipment, and supervision will lead to more child spacing acceptors.
Child spacing and maternal health services widely available in four provinces.	153 public sector and 145 private health services centers equipped, provided with commodities and staffed by trained personnel. Increase in CYP from 30,000 to 120,000.	MOPH/DFMI service statistics and acceptor records. Site visits and reports. Contraceptive warehouse records.	An unmet demand for child spacing/maternal health services already exists in Cameroon.
Institutionally strengthened DFMI	Improved procedures, management and planning.	Site visits, evaluations and project implementation reports.	USAID or other donors continue to supply contraceptives.
Expanded condom social marketing program.	Increase in sales outlets from approx. 200 to 1500.	Sales records. Contraceptive warehouse records.	
Cadre of national and provincial trainers identified and trained in child spacing/maternal health and curricula developed for in-service training.	30 trainers trained. Training manuals produced.	Training records Review of materials.	
Contraceptives integrated into PIC logistic and distribution systems.	Adequate contraceptive supplies available at PIC outlets and pharmaceutical depots.	Contraceptive warehouse records, site visits, and evaluations.	MOPH drug distribution system for PIC functions adequately.

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NATIONAL FAMILY HEALTH PROJECT LOGFRAME

<u>NARRATIVE SUMMARIES</u>	<u>OBJECTIVELY VERIFIABLE INDICATORS</u>	<u>MEANS OF VERIFICATION</u>	<u>ASSUMPTIONS</u>
PROJECT INPUTS			
Technical assistance obtained through buy-ins to four centrally-funded cooperating agencies (CAs).	Budgeted amounts are obligated and expended.	Inspections, site visits, reports of the CAs, implementation reports, and evaluations.	Annual funding will be available for the project.
Contraceptives, equipment and supplies.	Annual procurement of commodities.	PIO/Is and PIO/Cs. Warehouse receipts.	Buy-in mechanisms continue.
Funds for in-country training.	Budgeted amounts are obligated and expended.	Financial records of cooperating agencies. Training records.	
Project management support through locally hired personal services contractor (PSC).	PSC hired.	Employment contract and financial records.	

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Annex C
Statutory Checklists

Annex C

Country Checklist

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1990 Appropriations Act Sec. 569(b). Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? No

2. FAA Sec. 481(h); FY 1990 Appropriations Act Sec. 569(b). (These provisions apply to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government): (a) Does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement? and NA

lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

4. FAA Sec. 620(c). If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

No

5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

No

6. FAA Secs. 620(a), 620(f), 620D; FY 1990 Appropriations Act Secs. 512, 548. Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside

No

(b) Has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (1) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (2) the vital national interests of the United States require the provision of such assistance?

3. 1986 Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h), has the President submitted a report to

NA

Congress listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to

lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

4. FAA Sec. 620(c). If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity? No
5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No
6. FAA Secs. 620(a), 620(f), 620D; FY 1990 Appropriations Act Secs. 512, 548. Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside No

- Afghanistan through the Soviet-controlled government of Afghanistan?
7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? No
 8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC? No
 9. FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? No
(b) If so, has any deduction required by the Fishermen's Protective Act been made?
 10. FAA Sec. 620(q); FY 1990 Appropriations Act Sec. 518 (Brooke Amendment). (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (a) No
(b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds? (b) No
 11. FAA Sec. 620(s). If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.) NA
 12. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations No

been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

13. FAA Sec. 610(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.) Cameroon is not in arrears regarding its UN Obligations
14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism? No
15. FY 1990 Appropriations Act Sec. 564. Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons? (a) No
(b) No
16. ISDCA of 1985 Sec. 552(b) Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? No
17. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under FAA? No
18. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without No

specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

19. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? No
20. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.) No
21. FY 1990 Appropriations Act Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance? No
22. FY 1990 Appropriations Act Sec. 539. Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin? Yes

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria
- a. FAA Sec. 116. Has the Department of State determined that this government has No

engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

b. FY 1990 Appropriations Act Sec. 535. Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?

No

b. FY 1990 Appropriations Act Sec. 569(d). Has this country met its drug eradication targets or otherwise taken significant steps to halt illicit drug production or trafficking?

NA

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM



CHECKLIST BEEN REVIEWED FOR
THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1990 Appropriations Act Sec. 523; FAA Sec. 634A. If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified? No
2. FAA Sec. 611(a). Prior to an obligation in excess of \$500,000, will there be:
(a) engineering, financial or other plans necessary to carry out the assistance; (a) Yes
and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? (b) Yes
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? NA
4. FAA Sec. 611(b); FY 1990 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) NA
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? NA
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. No
7. FAA Sec. 601(a). Information and

- conclusions on whether projects will encourage efforts of the country to:
- (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
- (a) NA
(b) Yes
(c) No
(d) Yes
(e) Yes
(f) NA
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). The project will provide technological and human resources development for private sector which will create limited opportunity for U.S. trade.
9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. NA
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? NA
11. FY 1990 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? No
12. FY 1990 Appropriations Act Sec. 547. Will the assistance (except for programs in Caribbean Basin Initiative Countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. No

exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?
- (a) No
- (b) No
- (c) No
- (d) No
14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?
- NA
15. FY 1990 Appropriations Act, Title II, under heading "Agency for International Development." If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?
- NA
16. FY 1990 Appropriations Act Sec. 537. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?
- NA
17. FY 1990 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular
- NA

notification procedures?

18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision). The Grant Agreement will be below the minimum necessary for the application of this provision.
19. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2. Does the project use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Yes
20. FY 1990 Appropriations Act, Title II, under heading "Women in Development." Will assistance be designed so that the percentage of women participants will be demonstrably increased? Yes
21. FY 1990 Appropriations Act Sec. 592(a). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies, has A.I.D. (a) required that local currencies, be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account? NA
- Will such local currencies, or an equivalent amount of local currencies, be

used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1990 Appropriations Act Sec. 546 (as interpreted by conference report for original enactment). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers? (1) NA (2) NA

b. FAA Sec. 107. Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? Yes

c. FAA Sec. 281(b). Describe extent to which the activity recognizes the The project addresses health needs of 40% of the

particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

population, married couples of reproductive age; will train Cameroonians to provide leadership in the health sector and utilize local technical expertise in project implementation; and support development of community drug systems.

d. FAA Sec. 101(a) Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes

e. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will:
(1) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions;
(2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries.

(1) Project will encourage decentralized planning and development of community financed and managed drug supply systems and expand health services in rural areas.

(2) Project will encourage development of community financed and managed drug supply systems.

(3) Activity directly supports Cameroon's Structural Adjustment Program, especially the Social Dimensions of Adjustment program.

(4) Program is aimed directly at improving the health of women and skills of female health workers.

(5) Project will utilize technical assistance experts from other African countries.

f. FAA Secs. 103, 103A, 104, 105, 106 120-21; FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, Da." Does the project fit the criteria for the source of funds (functional account) being used?

Yes

g. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Have local currencies generated by the sale of imports or foreign exchange by the government of a country in

NA

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Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for use, in accordance with an agreement with the United States, for development activities which are consistent with the policy directions of Section 102 of the FAA and for necessary administrative requirements of the U.S. Government?

h. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Yes

i. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for "relatively least developed" country)?

Yes

j. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes

k. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

The Project addresses the health needs of 40% of the population, married couples of reproductive age; will utilize local technical expertise; and support development of decentralized planning.

l. FY 1990 Appropriations Act, under heading "Population, DA," and Sec. 535. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No

- Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? No
- Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? No
- Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? Yes
- In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? No
- Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No
- m. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes
- n. FY 1990 Appropriations Act Sec. 579. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? Some technical assistance will involve firms owned by economically or socially disadvantaged persons.

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o. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; and (11) utilize the resources and abilities of all relevant U.S. government agencies?

NA

p. FAA Sec. 118(c)(13). If the

No

assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project: (1) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (2) take full account of the environmental impacts of the proposed activities on biological diversity?

g. FAA Sec. 118(c)(14). Will assistance be used for: (1) procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

(1) No
(2) No

r. FAA Sec. 118(c)(15). Will assistance be used for: (1) activities which would result in the conversion of forest lands to the rearing of livestock; (2) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (3) the

(1) No
(2) No
(3) No
(4) No

colonization of forest lands; or (4) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

s. FY 1990 Appropriations Act Sec. 534(a). If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for

NA

sustainable forestry?

t. FY 1990 Appropriations Act Sec 534(b). If assistance relates to energy, will such assistance focus on improved energy efficiency, increased use of renewable energy resources, and national energy plans (such as least-cost energy plans) which include investment in end-use efficiency and renewable energy resources.

NA

Describe and give conclusions as to how such assistance will: (1) increase the energy expertise of A.I.D. staff, (2) help to develop analyses of energy-sector actions to minimize emissions of greenhouse gases at least cost, (3) develop energy-sector plans that employ end-use analysis and other techniques to identify cost-effective actions to minimize reliance on fossil fuels, (4) help to analyze fully environmental impacts (including impact on global warming), (5) improve efficiency in production, transmission, distribution, and use of energy, (6) assist in exploiting nonconventional renewable energy resources, including wind, solar, small-hydro, geo-thermal, and advanced

biomass systems, (7) expand efforts to meet the energy needs of the rural poor, (8) encourage host countries to sponsor meetings with United States energy efficiency experts to discuss the use of least-cost planning techniques, (9) help to develop a cadre of United States experts capable of providing technical assistance to developing countries on energy issues, and (10) strengthen cooperation on energy issues with the Department of Energy, EPA, World Bank, and Development Assistance Committee of the OECD.

u. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA". (as interpreted by conference report upon original enactment). If assistance will come from the Sub-Saharan Africa DA account, is it: (1) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (2) being

(1) Yes
(2) Yes

(1)

provided in accordance with the policies contained in section 102 of the FAA;
(3) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa;
(4) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take

(3) Yes

(4) Yes

into account, in assisted policy reforms, the need to protect vulnerable groups;
(5) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

(5) Yes

v. International Development Act Sec. 711, FAA Sec. 463. If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (1) the world's oceans and atmosphere, (2) animal and plant

NA

species, and (3) parks and reserves; or describe how the exchange will promote:
(4) natural resource management,
(5) local conservation programs,
(6) conservation training programs,
(7) public commitment to conservation,
(8) land and ecosystem management, and
(9) regenerative approaches in farming, forestry, fishing, and watershed management.

w. FY 1990 Appropriations Act Sec. 515.

If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

NA

2. Development Assistance Project Criteria (Loans Only)

NA

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

c. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

3. Economic Support Fund Project Criteria

NA

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part 1 of the FAA?

b. FAA Sec. 531(e). Will this assistance be used for military or

paramilitary purposes?

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. PROCUREMENT

- | | |
|--|---|
| 1. <u>FAA Sec. 602(a)</u> . Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? | The project will utilize established procedures to buy in to centrally funded contracts or cooperative agreements for TA and procurement of contraceptives. Small businesses may compete for financing other commodities. |
| 2. <u>FAA Sec. 604(a)</u> . Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him? | Yes |
| 3. <u>FAA Sec. 604(d)</u> . If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? | NA |
| 4. <u>FAA Sec. 604(e)</u> . If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) | NA |
| 5. <u>FAA Sec. 604(g)</u> . Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code | NA |

941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

(get new language from 3M(3)-1 of new checklist)

6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1986, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No

7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? (new language on pg 3M(3)-2) Yes

8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available. Yes

9. FY 1990 Appropriations Act Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? Yes

10. FY 1990 Appropriations Act Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? Yes

11. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2. Does the project use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Yes
12. FAA Secs. 612(b), 636(h); FY 1990 Appropriations Act Sec. 507, 509. Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services No appreciable foreign currency generated.
13. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No
14. FAA Sec. 601(e). Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes
- B. CONSTRUCTION
1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? NA
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? NA
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress? NA
- C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? NA

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Controller General have audit rights? NA

3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes

4. Will arrangements preclude use of financing:
 - a. FAA Sec. 104(f); FY 1990 Appropriations Act under heading "Population, OA," and Secs. 525, 535.
 - (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (1) Yes
 - (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (2) Yes
 - (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion?

 - b. FAA Sec. 483. To make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes

 - c. FAA Sec. 620(q). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes

 - d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes

- e. FAA Sec. 662. For CIA activities? Yes
- f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes
- g. FY 1990 Appropriations Act Sec. 503
To pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes
- h. FY 1990 Appropriations Act Sec. 505.
To pay U.N. assessments, arrearages or dues? Yes
- i. FY 1990 Appropriations Act Sec. 506.
To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes
- j. FY 1990 Appropriations Act Sec. 510.
To finance the export of nuclear equipment, fuel, or technology? Yes
- k. FY 1990 Appropriations Act Sec. 511.
For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes
- l. FY 1990 Appropriations Act Sec. 516;
State Authorization Sec. 109. To be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? Yes
5. FY 1990 Appropriations Act Sec. 574.
Will any A.I.D. contract and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? Yes
6. FY 1990 Appropriations Act Sec. 582.
Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person

in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

No

3(A)2 - NONPROJECT ASSISTANCE CHECKLIST

The criteria listed in Part A are applicable generally to FAA funds, and should be used irrespective of the program's funding source. In Part B a distinction is made between the criteria applicable to Economic Support Fund assistance and the criteria applicable to Development Assistance. Selection of the criteria will depend on the funding source for the program.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED?

A. GENERAL CRITERIA FOR NONPROJECT ASSISTANCE

1. FY 1990 Appropriations Act Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project.
2. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?
3. FAA Sec. 209. Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.
4. FAA Sec. 601(a). Information and conclusions on whether assistance will encourage efforts of the country to:
(a) increase the flow of international trade; (b) foster private initiative and

competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

5. FAA Sec. 601(b). Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).
6. FAA Sec. 121(d). If assistance is being furnished under the Sahel Development Program, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of A.I.D. funds?

B. FUNDING CRITERIA FOR NONPROJECT ASSISTANCE

1. Nonproject Criteria for Economic Support Fund
 - a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?
 - b. FAA Sec. 531(e). Will assistance under this chapter be used for military or paramilitary activities?
 - c. FAA Sec. 531(d). Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106?
 - d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?
 - e. FY 1990 Appropriations Act, Title II, under heading 'Economic Support Fund.'

and Sec. 592. If assistance is in the form of a cash transfer: (a) Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds? (b) will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements? (c) Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available? (d) Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

2. Nonproject Criteria for Development Assistance

a. FAA Secs. 102(a), 111, 113, 281(a).
Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help

efforts of developing countries;
(4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

b. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Is assistance being made available (include only applicable paragraph which corresponds to source of funds used; if more than one fund source is used for assistance, include relevant paragraph for each fund source):

(1) [103] for agriculture, rural development or nutrition; if so (a) extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, account shall be taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made; (b) extent to which assistance is used in coordination with efforts carried out

under Sec. 104 to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people; and (c) extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

(2) [104] for population planning under Sec. 104(b) or health under Sec. 104(c); if so, extent to which activity

emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

(3) [105] for education, public administration, or human resources development; if so, (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education

and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

(4) [106] for energy, private voluntary organizations, and selected development problems; if so, extent activity is:

(i)(a) concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and (b) facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

(ii) concerned with technical cooperation and development, especially with U.S private and voluntary, or regional and international development, organizations;

(iii) research into, and evaluation of, economic development processes

and techniques;

(iv) reconstruction after natural or manmade disaster and programs of disaster preparedness;

(v) for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

(vi) for urban development especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

(5) [120-21] for the Sahelian region; if so, (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom)?

DRAFTER:GC/LP:EHonnoId:3/20/90:2169J

FAMILY HEALTH SUPPORT PROJECT
NOTES ON COST ESTIMATES

1. Technical Assistance: Short Term

From USA - Salary	\$225/day * 24 days	= \$ 5,400
Per Diem	\$190/day * 30 days	= \$ 5,700
Airfare	\$4000/trip	= \$ 4,000
Local Travel		= \$ 200
Miscellaneous		= \$ 200
		=====
Total		= \$15,500

From Lome- Salary	\$225/day * 24 days	= \$ 5,400
Per Diem	\$190/day * 30 days	= \$ 5,700
Airfare	\$1,000/trip	= \$ 1,000
Local Travel		= \$ 200
Miscellaneous		= \$ 200
		=====
Total		= \$12,500

Cameroon - Salary \$190/day * 20 days = \$ 3,800

2. Training

Trainer's Expenses - \$1000/wk for honorarium, plus \$69/day for per diem

Participant Expenses:

Per Diem - \$69/day or \$52/day depending on the category of health provider.

Travel - \$52/participant or \$17/participant, depending on the site for training.

Materials - \$25/participant for all courses, except for \$300/participant for courses for clinical preceptors or with IUD, and \$600/participant for courses with Minilap training.

3. IEC Materials

From budget estimates for current JKU/PCS activities in Cameroon.

4. Contraceptives

Unit cost estimates according to guidelines from Commodities Division, ST/POP. Freight costs for air freight.

5. Host Country Contribution

The Government of the Republic of Cameroon (GRC) will make in-kind contributions minimally of US\$ 3,137,500 over the LOP, equal in value to 39 percent of USAID's contribution to the project. The value of the GRC's in-kind contribution was estimated as follows:

GRC's Budget for Health Sector (1990/1):	FCFA 22.75 billion
Percent Allocated to Salary Payments:	80%
Percent of MOPH FHC Staff in Provinces under the Project:	20%
Percent of Staff Time Allocated to Family Health Activities:	5%
FCFA 290 per US\$ 1.00	
	=====
Estimated Value of GRC In-kind Contribution per Year	US\$ 627,500
Estimated Value of GRC In-kind Contribution over LOP	US\$ 3,137,500

In addition, the GRC will provide in-kind contributions to the project in the form of: i) use of government training facilities, ii) use of service delivery sites, and iii) space at the Central Warehouse for ONAPHARM. The individuals and communities which will benefit from the family health services which will be promoted under this project will also contribute to the sustainability of these activities through user fee payments at private and public sector health institutions. A rough estimate of the cash payments to the PHC systems in the 4 provinces would be US\$ 4.0 million over the LOP, with a portion of this attributed to the provision of MCH-related services.

Annex D

HC Request for Assistance

HC Request for Assistance

MINISTÈRE DE LA SANTE PUBLIQUE
MINISTRY OF PUBLIC HEALTH

RECEIVED
USAID YAOUNDE

REPUBLIQUE DU CAMEROUN
Pax - Travail - Paix
REPUBLIC OF CAMEROUN
Peace - Work - Fairness

N° 22011/MSP/SG/DSP/1148 4 3 25 PM '91

Yaoundé, le 01 MARS 1991 19

Réf. : V/L/USAID/EHRD/HNP
Ref. OF FEB. 15 - 1991.

OFFICIAL FILE COPY
DO NOT REMOVE

Le Ministre de la Santé Publique
The Minister of Public Health

LCP 3

Objet : Design of New USAID Health Projects : MR JAY P. Johnson DIRECTOR USAID
Subject: Projects.

B.P. 817

YAOUNDE

ACTIVITE, COPY
12 <u>RAHUR</u>
TRASSE
TRASSE
TRASSE

Sir Director,

Thank you for the New USAID Health Project on "Integrated Family Health". This project touches the priorities of our health programme namely Prevention activities delivered through the national primary health strategy and addressing maternal and child health as well as other key issues.

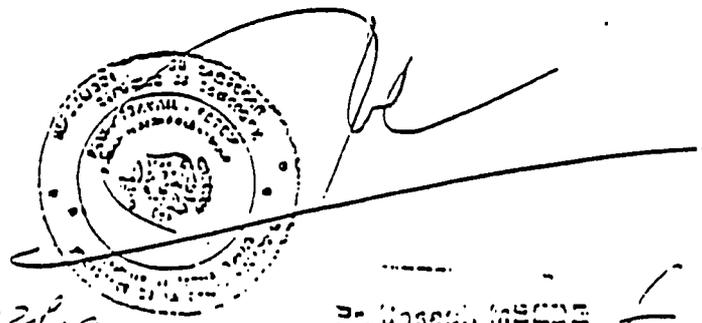
The "Primary Health Care sub-sector Reform" program is a really neat assistance and I hope it will enhance the implementation of the Primary Health strategy nation wide, hence bringing health closer to the people.

The Director of Family and Mental Health and the Director of Preventive Medicine and Rural Health as well as their respective staffs are fully aware of the Technical Assistance team coming in April, 1991. These technical services will offer maximum participation to ensure the development of a health programme which reflects our policy and the concerns of USAID.

Thanks for your continuous support and collaboration.

Sir, accept the assurances of my highest consideration./-

ACTION : EHRD/HNP
INFO : MR
06/16/91 EHRD
CITRON
RF



Dr. Joseph NDEBE



UNITED STATES OF AMERICA
AGENCY FOR INTERNATIONAL DEVELOPMENT

Yaounde

UNITED STATES ADDRESS :
YAOUNDE (AID)
DEPARTMENT OF STATE
WASHINGTON, D. C. 20520

INTERNATIONAL ADDRESS
USAID
S. P. 817
YAOUNDE, CAMEROON
TEL : 22-05-81
22-02-69

FEB 15 1991

USAID/EHRD/HNP/0285

His Excellency
Professor Joseph Mbede
Minister of Public Health
of the Republic of Cameroon
Yaounde

Subject: Design of New USAID Health Projects

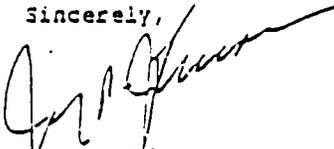
Dear Mr. Minister:

I am pleased to inform you that USAID will be designing two new health projects for Cameroon during the month of April. The basic concepts for these projects have been discussed in detail with Ministry of Public Health (MOPH) personnel. The proposed 'Integrated Family Health' Project would support the national primary health care program by integrating child spacing and key maternal health services into the service delivery strategy. The 'Primary Health Care Sub-sector Reform' Program would assist the MOPH to officially adopt several important policy reforms directly related to the implementation of the primary health care strategy nationwide.

USAID hopes to obtain funds for both initiatives this year. For that reason timing is critical, making it advantageous to design the projects at the same time. In order to facilitate the design process, USAID requests that the Director of Family and Mental Health and the Director of Preventive Medicine and Rural Health and their respective staffs make themselves available for consultation during April. For our part, USAID will engage a technical assistance design team to work closely with these two directorates to assure that the design process is a truly joint effort and reflects the policy and implementation concerns of both USAID and the MOPH.

USAID looks forward to working closely with the MOPH in the design of these two important projects.

Please accept, Excellency, the assurances of my highest consideration.

Sincerely,

Jay P. Johnson
Director

- CC: Dr. Owona, Director of Preventive Medicine, MOH.
- Dr. David Awasum, Director of Family and Mental Health, MOH.
- The Secretary General, Ministry of Finance
- The Director of Technical Cooperation, Ministry of Plan and Regional Development

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Annex E
Project Analyses

Annex E

Project Analyses

Administrative

I. Introduction

The purpose of this section is to determine whether the best alternatives for assigning implementation responsibility for project activities have been identified. To do this, we will examine the likelihood that the Ministry of Public Health, contractors, other participants (including the private and parastatal sector and the religious NGOs) and AID can meet the responsibilities assigned to them. Chapter VI in the body of this paper presents the management plan for the project. To examine the feasibility of this, we will review information on management, organizational experience and staffing of these organizations, including their relationships with each other.

II. Public Sector

Independent in 1960, Cameroon was divided into two states, one Anglophone and one Francophone, each with its own administration. In 1972 the two states were united by referendum into the United Republic of Cameroon, which became the Republic of Cameroon with a revision of the Constitution. The legacy left by the English and French colonials of two separate languages means the even now, Cameroon is bilingual, if only officially.

Multiparty politics in Cameroon ended in 1966 with the creation of the Cameroon National Union (UNC) under then President Ahidjo. The UNC was replaced by the Cameroonian People's Democratic Movement (CDPM or RDPC). Only in the last year have multiparty politics been reinstated with tight controls.

Administratively, the country is divided into ten provinces, which are further divided into 49 departments and 182 arrondissements.

BREAKDOWN OF ADMINISTRATIVE UNITS BY PROVINCE

<u>Province</u>	<u>Provincial Seat</u>	<u>#Dept</u>	<u>#Arron</u>
Adamaoua	Ngaoundere	5	11
Centre	Yaounde	8	39
Est	Bertoua	4	16
Ext. Nord	Maroua	6	21
Littoral	Douala	4	19
Nord	Garoua	4	10
Nord-Ouest	Bamenda	5	11
Ouest	Bafoussam	6	24
Sud	Ebolowa	3	14
Sud-Ouest	Buea	4	17
TOTAL		49	182

Source: Ministry of Territorial Administration

The provinces are placed under the authority of a governor who represents the central power and is appointed by the President. Different ministries are represented in the provinces by delegates, who are also under the authority of the governor. There are provincial delegates for Plan and Territorial Administration, Health, Education, Social and Women's Affairs and Agriculture who are also all members of the provincial

development committee, presided by the governor. At the level of the department, the prefect, assisted by an assistant for economics, coordinates the activities of the departmental directors of these same ministries. The prefect also presides the Departmental Development Committee. At the level of the arrondissement, the sous-prefect has a coordination role. The overriding characteristic of the Cameroonian administration is that it is highly centralized.

The Ministry of Public Health's bureaucracy mirrors the central authority's, and is discussed below.

A. Health Management at the Central Level

In January 1989 a presidential decree decided the reorganization of the Ministry of Public Health. Under the Minister are:

- a general inspection
- two technical counsellors
- a central administration
- external services (provincial services)

The Inspector General is responsible for the technical and administrative control of the central and provincial services and undertakes any mission or inquiry which the minister asks. The Inspector General has two people responsible for studies (charges d'etudes).

The technical counsellors' sole duty is to perform work asked of them by the Minister. One of the technical counsellors is the director of UNICEF- funded Primary Health Care program.

The central administration of the ministry is composed of six general directorates which are directly under the General Secretariat:

Directorate of Hospital Medecine
Directorate of Preventive and Rural Medecine
Directorate of Family and Mental Health
Directorate of Pharmacy
Directorate of Studies, Planning and Health Statistics
Directorate of General Affairs

There appears to be some redundancy and an apparent lack of coordination between and among directorates. For example, although there is a directorate responsible for health statistics, a service or sub-service for statistics exists in almost every directorate.

Two directorates will have implementation responsibilities under this project, the Directorate of Family and Mental Health (DFMH) and the Directorate for Preventive and Rural Medecine (DPRM), with the DFMH taking primary responsibility. Only these two Directorates will be discussed in detail.

1. The DFMH was created in January 1989 with the reorganization of the Ministry. It is composed of two sub-directorates: family health and mental health.

The sub-directorate of family health has three services:

- a. maternal, infantile and juvenile health
- b. nutrition
- c. health education

The first is responsible for organization and implementation of medical care for the mother and child, coordination for the approximately 55 Protection Maternelle et Infantile (PMI) centers located throughout the country, inspection of maternities, family planning and the fight against genetic diseases. Four offices are under this sub-directorate:

- a. The office of Family Protection
- b. The office of Immunizations
- c. The office of Genetic Diseases
- d. The office of Control and Statistics

The Nutrition service is responsible for identification of solutions for and prevention of nutritional problems, food and nutrition information, nutritional surveillance, quality control of food found on the markets and training of medical and paramedical personnel in nutrition. The service has three offices:

- a. The office of surveys, surveillance and nutritional education
- b. The office of control of food markets
- c. The office of dietetics and documentation

The service of Health Education has a broad mandate to organize, supervise and coordinate all health education activities to sensitize the population to take control of their own health and to prepare educational objectives for retraining the health personnel who participate in health education. It also assures collaboration within the Ministry for all PMI, hygiene, nutrition and epidemiological activities. In addition, Health Education tries to integrate health education into the schools and other training centers.

The Health Education service has three offices:

- a. The office of Health Education
- b. The office of Production and Distribution of educational audio-visual materials
- c. The office of Research and Evaluation of Educational Actions

The second sub-directorate within the DFMH is for Mental Health, which has two services: Mental Hygiene and Psychiatry, and Addictions and Alcoholism. The two offices under the Mental Hygiene and Psychiatry service are:

- a. The office of Mental Hygiene
- b. The office of Statistics for Psychiatric Centers.

The second service also has two offices:

- a. The office of Addictions
- b. The office of Surveys

Overall responsibility for project implementation will be with the DFMH. The DFMH will develop technical and policy guidelines, materials and protocols necessary to launch a national child spacing/maternal health program; plan the implementation of the program; and monitor and evaluate the program.

Specific responsibilities will be:

- development of child spacing/ maternal health medical standards and service delivery protocols;
- design, testing, production and distribution of IEC materials;
- elaboration of in-service training curricula consistent with the prevailing PHC training strategy;
- design of supervision and information instruments which will be integrated into the PHC program;
- forecasting and procurement of contraceptives and equipment for distribution to the provinces;
- strategic planning for the rational expansion of child spacing/ maternal health activities on a national scale;
- harmonization and coordination of public and private sector child spacing/maternal health service delivery strategies. This will include assuring that all private sector providers employ the same medical and referral standards, in-service training curricula and IEC programs and materials.

This project will be a major undertaking for the DFMH, especially since it has overall management responsibilities for the project. Although it is new its personnel including the director, already have some experience with AID projects or programs. The DFMH is familiar with the ongoing family planning activities of USAID, as implemented through SEATS, PCS and JHPIEGO. SEATS will provide a resident technical advisor for the DFMH who will be responsible for assisting in the administrative, financial and logistics management of the project, assisting as necessary with the MIS, monitoring the program with the Director and providing advice on coordination, supervision and organization of the program.

The DFMH will depend heavily on the Provincial Health Directorates and the DPRM for inclusion of these activities into the reorientation and the execution of the project in the provinces.

2. The DPRM is composed of a service of public hygiene and two sub-directorates: Epidemiology and Rural Medecine.

The public hygiene service participates in the fight against vectors of contagious diseases and in the rules regarding liquid, solid and gaseous debris as they relate to public health. This service has two offices:

- a. The office of inspection and control of hygiene
- b. The office of reglemantation and standardization

The sub-directorate of Epidemiology is responsible for epidemiological surveillance and mapping, planning and implementation of epidemiological activities, epidemiological statistics, prevention and prophylaxis and training in epidemiology. Epidemiology has two services:

- a. Epidemiology
- b. Fight against endemno-epidemics

The Epidemiology service's two offices are the office of epidemiological surveys and the office of statistics. The service for the fight against endemno-epidemics has four offices:

- a. The office of Leprosy-Tuberculosis
- b. The office of Malaria and Trypanosomiasis

- c. The office of Schistosomiasis-Onchocerosis- Dracunculosis
- d. The office of Sexually Transmitted Diseases

The sub-directorate of Rural Medecine is in charge of all activities in rural health centers, primary health care and supervision and evaluation of the activities in the rural health centers. Two services function under this sub-directorate.

The Rural Health Centers service is responsible for governmental policy for rural medecine, the functioning of rural health centers, planning and programming for the creation of new ones, technical control for health centers, including private ones and planning for supplies for the health centers. It has two offices:

- a. The office of programming and statistics
- b. The office of supervision and control

The second service under Rural Medecine is that of Community Health and Traditional Medecine. It is divided into three offices:

- a. The office of projects and evaluations
- b. The office of training and orientation
- c. The office of traditional medecine

As part of its role of overall coordination and implementation of the national PHC program, the DPRM will have several responsibilities in this project:

- assure the effective integration of the project activities into the provincial health delivery systems;
- assure that child spacing/ maternal health supervision and information guidelines are effectively integrated into the PHC supervision and information systems;
- assure that IEC and training strategies and materials developed by the DFMH are compatible with the PHC program and are effectively integrated into the program; in this regard, the DPRM will provide input into the elaboration of training and IEC materials and programs.

The DPRM has the main responsibility for prevention and primary health care and their implementation in the provinces. A successful project depends on close collaboration, coordination and supervision between the DPRM and DFMH.

B. Health Management in the Provinces

At the provincial level, the delegate is the Minister's representative and is responsible for all health activities in the province. Reporting directly to the Provisional delegate are the provincial Chief of Preventive Medecine and Public Hygiene, who oversees all preventive medecine activities, and the chief Medical Officer, who is the director of the provincial hospital. Each directorate of the Ministry is represented at the provincial level as a service. The six services each have two or three offices.

At the department level, the person responsible for health is the chief medical officer, who is also responsible for managing the departmental hospitals and supervising the medical staff of the arrondissement hospitals. Overseeing all preventive activities in the department, as well as the health centers, is the chief of preventive and rural medecine. Both the chief medical officer and the chief of preventive and rural medecine report directly to the provincial delegate.

At the arrondissement level are the arrondissement hospital and the health centers and health posts. A chief of service for health is responsible for the functioning of the arrondissement hospital and the organization, supervision and control of all medical and health facilities and public health in the arrondissement. The arrondissement chief of service reports to the chief of public health at the departmental level.

Primary health care is delivered through a network of health centers and village health posts (although the health posts are considered outside of the public sector). There are approximately 600-800 functioning health centers in Cameroon. Under the reorientation of primary health care, discussed below, the health center will be the basis for care, and will have a defined catchment area.

Project responsibilities for the provincial health delegations, who will work closely with donor agencies supporting PHC in their provinces will include:

- Planning the launch of child spacing/maternal health activities into their provinces by including these activities in provincial implementation plans;
- Assuring that health districts include the launching and implementation of child spacing and maternal health services in their annual PHC plans;
- Identifying provincial child spacing/maternal health trainers and training sites;
- Assuring that the health districts implement the training and other activities necessary to fully integrate child spacing/maternal health into the PHC service delivery system;
- Assuring that contraceptives, maternal health equipment and drugs, IEC materials, and other supplies are placed in the provincial drug and medical supply system and that intermediate depots and hospital and health center pharmacies maintain a steady and adequate supply of these commodities.

Donor agencies have noted that in general, implementation of health programs is easier in the provinces because the health personnel involved are fewer and the problems closer to home. AID experience with the reorientation of PHC thus far has found this to be true. This project will depend to a large extent on the implementation of the PHC in the provinces and the willingness and acceptability by the provincial teams to include family planning. However, few staff have yet received training in IEC and counselling for family planning, STDs, infertility or clinical training in family planning methods, including practicum for IUD insertion and removal and for laparotomy. One of the main thrusts of this project is to provide that training, and to institutionalize the training by training provincial teams to deliver most of the training.

D. Organizational Weaknesses

1. During most of its existence, the MOPH has concentrated on curative care, with budgets for hospitals, especially in Yaounde and Douala far outweighing primary health care. The religious and private sectors are responsible for over 50% of the health care that is provided in Cameroon. This represents a systematic failure on the part of the MOPH.

2. There is a plethora of MOPH personnel, especially in the cities and the PMIs. Neither the Ministry of Finance nor the MOPH itself can declare how many personnel the MOPH has, but there is a 7,000-person discrepancy between the Ministry of Finance and MOPH in counting MOPH personnel. Ministry of Health is trying to reconcile it now. The PMI central in Yaounde has 127 staff, of which 5 are midwives. They see 200 new cases a week. The PMI in Bafoussam has a staff of 70 persons, including 42 aides soignants who see a total

of 50- 60 patients a day. In the same city, at the hospital maternity which has 150 deliveries a month, a staff of 28 is employed.

3. Many of the activities and responsibilities of the DFMH and the DPRM are very similar. PMIs are attributed to and supervised by the DFMH, while all other primary health care comes under DPRM. Each has certain responsibilities for EPI, for example.

4. The public health system has suffered from a lack of clients, due to a lack of confidence because of the absence of drugs, ability to diagnose, and low or no motivation on the part of the health staff. Visits to the interior revealed that the departmental and arrondissement level hospital are practically empty of clients, while the religious and private clinics are overflowing. Indeed, at the MOPH sites, many of the staff don't even show up for work.

5. There is about a 50% turnover of health staff at any given site every three years. For this project, this means that training programs will need to train again after three years in order to ensure that personnel at target sites are qualified to perform the services required.

6. All personnel are posted directly from the central level in Yaounde. This means that not even a provincial delegate can control the postings in his province, much less a head of a health clinic in his clinic. According to a recent trip report of a World Bank team, this centralization of management means that there is no room for manoeuvring for managers at other levels to manage, organize, sanction, supervise or evaluate their employees. Often, people are "protected" by a friend or family member higher up so they are posted to Yaounde or Douala and not to the departments.

7. According to the DFMH, only 60% of the department level hospitals are functional.

C. Organizational Strengths

1. A Monitoring Committee for health has just been created. All actors in health, including other donors, churches, ministries, ONGs, etc. are involved. There will be a sub-committee for different sectors--family planning, immunizations, etc., which, if used, could be effective to coordinate different health sectors, or actors within a sector, i.e., family planning.

2. There is a great number of health infrastructures throughout the country, many at the health center level and many quite new. There are still regional disparities in their distribution, however.

3. Initial training of health personnel, especially from CUSS and CESSI, is recognized as high quality.

4. A great number of health personnel already exists, probably too many. There is a challenge for the Ministry to assign them all to posts where their skills can be put to best use.

5. The recent reorganization of the MOPH, as described above, recognized that there needed to be a better rationalization of the Ministry. This was a very pragmatic move by the government, because it recognized the fact that the government could no longer pretend to provide free health care to its population, or that it reaches the whole population.

6. Provincial delegations are well-organized and equipped.

2. MINASCOF- The Ministry of Social and Women's Affairs (MINASCOF) will be minimally involved in this project through some of its 26 Maisons de la Femme. The Maisons de la Femme are generally located in the country's major cities and are RDPC (the political party in power) structures. They are under the authority of the MINASCOF and have three-pronged programs: Medical, social and educational. Already UNFPA and USAID (through SEATS) is implementing some of its family planning activities in Maisons de la Femme.

The supervisory and management structure of the Maisons de la Femme is officially under MINASCOF, but because at least two other ministries and often more provide personnel, lines of authority and supervision are very unclear. In the model Maison de la Femme in Tsinga, Yaounde, there are 20 MINASCOF, personnel, 38 from MOPH, 12 from the Ministry of Education.

B. Reorientation of Primary Health Care

1. A brief summary of this reorientation follows:

In May, 1989, the MOPH released a new strategy for primary health care. The strategy will help organize PHC so that local communities take responsibility for their own health care. It is based on community management of the health care and the proceeds charged for the care. It is also based on the administrative units.

Each political sub-division (arrondissement) in the country will be organized as a health district and will receive training, technical and administrative support from the departement and provincial levels. The health districts will be divided into health areas (aires de sante), each of which will have a health center and a catchment area of about 3-15,000 people. The focus of the new program will be here. Each health center will have a drug store (stocked with essential drugs including contraceptives) and other cost recovery mechanisms which will be co-managed by the community health committees. One community health committee will represent all of the villages in the health center's catchment area.

Similarly at the sub-division level, a health committee will be created consisting of representatives from the different health committees. This committee will also form a management committee to oversee the hospital and the drug depot, if there happens to be one there. At the sub-division level, a team consisting of the PHC coordinator and one or two other persons will be responsible for coordinating all PHC activities throughout the sub-division (arrondissement).

The division (departement level) will provide supervision for the sub-division, which, in turn, provides it for the health centers. The provincial level will provide support and supervision to the departments and its hospital will serve as the reference hospital for the sub-divisions. The provincial level will also have a health committee made up of representatives from the sub-divisional committees. A management sub-committee at this level will oversee the management of the provincial hospital and the drug depot.

Committees

The MOPH has directed the membership of each of the committees at each level and has directed the frequency of their meetings.

The Health Committee at the health center level will be entirely elected by the population (one from each village in the catchment area of the health center.) The health management committees will consist of three persons, a president and treasurer elected by the community,

and a staff member from the health center. These committees will participate with the health personnel in the co-management of the health centers and will manage the pharmacy and cost-recovery mechanisms.

At the sub-divisional or arrondissement level, the Health committee is a sub-committee of the sub-divisional development committee.

The management committee at this level will be composed of several members, including representatives from each health center. The composition of these arrondissement level health and management committees is being revised as a result of the emerging multiparty political system. At the present time, there are RDPC party members on the committees, but plans are that the membership be all elected.

2. Integration of Family Planning into the PHC system-

This project will undertake to integrate child spacing into the reorientation of PHC in four provinces: South, Adamaoua, Center and Extreme North. Progress is already being made in these four provinces to install the new system and is probably most advanced in the South and Adamaoua provinces.

Coordination of this integration will be assured by a clear delineation of responsibilities and the cross approval of important texts. There is a history of good coordination of health activities at the province level.

The project will take advantage of the presence of USAID-funded primary health care activities in three of the four provinces, and of UNICEF's presence in PHC in the Center province. Under these PHC projects, provincial teams are being trained to train their health staffs in the reorientation program, how it will operate, the community participation and management, the development of plans for each province, departement, arrondissement and health center (including the delineation of each of the aires de sante), the system of supply and supervision, etc. At the same time, beginning with the communities and villages concerned, sensitization campaigns are being held to let people know what the reorientation plans are, to elicit village and community support for it, and to form village and community health committees. This is the groundwork for the reorientation.

Once the committees, the health centers and the pharmacies are functioning, topics in PHC will be introduced one by one, through training and the supply of appropriate commodities, drugs and services. For example, pre-natal care, ORS, family planning, vaccination, nutrition, etc., will each be topics of training programs which will then be integrated into the repertoire of services that the health centers and hospitals can provide.

This project will provide the training, supplies, and drugs for the child spacing component of this system. Child spacing will also be one of the topics of regular supervision and supply (through provision of contraceptives). In this way, integration of this project into the whole primary health care system is assured. It is fortuitous that the PHC system in the country is being overhauled now because it is the best time to introduce this new health component to ensure its integration.

3. Motivation for Health Personnel to Participate in the Program

A key factor in the success of this project will be the full and active participation of health personnel in child spacing/maternal health activities. Motivations for health personnel to participate in the project include:

- training opportunities which will improve health worker skills and provide clinicians with the confidence to deliver quality child spacing/maternal health services;
- IEC efforts which will motivate health workers to deliver child spacing/maternal health services as a key element of PHC;
- the integration of the project with the reorientation of PHC which links health workers administratively and financially (through forms of profit sharing) to the communities which they serve; and
- the provision of basic equipment, drugs, and other supplies to health centers which will permit health workers to effectively perform their jobs and deliver quality PHC and maternal health services.

C. CUSS

The Centre Universitaire des Soins de Sante will be responsible for the pre-service component of this project and will work with JHPIEGO, as it has for several years. The Cameroonian project director will be the same CUSS professor as in the past. The JHPIEGO component of the project is already funded under a separate agreement, but plays an integral part in the project, because it will complete development of the child spacing/maternal health curricula for CUSS and CESSI, the advanced Nursing school.

Assuming that the project will be managed as in the past, no administrative problems are foreseen.

III. Private Sector and Parastatals

A. Private Clinics and Parastatals

As many as 15 parastatal companies and 20 private for-profit health clinics will be involved in this project. SEATS will provide a resident manager to coordinate, provide logistics and technical assistance to the private sector (including the confessional) in launching child spacing activities.

Private for-profit clinics generally cater to the elite or at least the well-to-do in the cities, as their services are more expensive and the quality of care is usually better. As they are for-profit, their staffs are not heavy compared to the number of clients they see. They are out to make a profit, and that is the basis of their calculations. Selected private clinics will receive training in child spacing, some equipment as required, start-up supplies of contraceptives, IEC materials, and a start-up supply of client forms and registers. These clinics will also benefit from the medical standards and service delivery protocols which will be developed for nationwide application. Many clinics the design team visited already have plans for how to use the inputs they may receive.

The parastatal companies targeted under this project all have some kind of health services they provide to their employees and families. The largest, the Cameroon Development Corporation (CDC), is discussed below. Others include Brasseries du Cameroon, the National Workers' Union,

and other smaller ones. In addition to the services which will be provided to the for-profit clinics, the parastatal clinics will also receive sensitization of managers regarding the costs and benefits of providing child spacing services. The project assumes that only companies and clinics who believe they can effectively manage the inputs of this project will want to participate.

B. CDC

The Cameroon Development Corporation is the largest employer besides the state in Cameroon. It was begun by the British in 1947 and is Cameroon's major producer of bananas, tea, rubber and palm oil with 40,000 hectares under cultivation in four provinces. CDC employs about 16,000 workers and provides health care for the workers and their families (over 80,000 people in all). Based on a recent performance contract, cost for medical care is deducted from workers' salaries on a scale commensurate with the ability to pay.

CDC's health system is based on 67 aid posts, 19 clinics which are located on most of the CDC estates, and three hospitals which serve as reference centers for the clinics. CDC Health Office is already doing some family planning activities, and has identified priority clinics for the first year of the project based on catchment area. A minilaparotomy training was held by the MOPH in conjunction with SEATS recently. Organizers had a target of 60 clients for voluntary sterilization, but 175 women showed up for the procedure.

The Chief Medical officer, responsible for all the hospitals, centers and aid posts, has elaborated a monitoring and supervision system adequate for implementing and supervising child spacing and maternal health activities. Five doctors visit the estate clinics on a weekly basis, both as supervision visits and to treat the sick. Each center also has its own pharmacy where the initial supply of contraceptives will be placed. CDC employs its own pharmacist who is responsible for the drug and medicine supply for all the clinics. Already, CDC has begun some Family planning activities under the SEATS buy-in.

Organizationally, CDC is ready and able to integrate family planning into its whole health system. They are very anxious to begin using IEC materials to sensitize their client population. Family planning in the CDC should move fast, as they want to integrate all 19 clinics quickly.

IV. Religious

A. FEMEC

The Federation of Evangelical and Mission Churches (FEMEC) groups together all the protestant churches in Cameroon and is a very influential religious organization in the country. FEMEC is a very organized and efficient organization. It has already formed a committee to prepare a proposal for integrating family planning into 20 of its members' hospitals and up to 60 of their satellite clinics over the five years.

FEMEC is organized with an elected president at its head, a secretary-general who oversees the running of the organization and the activities of the various directorates education, religion, health, medical, women's affairs, and youth.

FEMEC already is very sensitive to the fact that all its member church hospitals and clinics may not be ready to provide family planning services at the same time so is planning to phase its activities this way. It is also planning to host a symposium for all its members to begin the sensitization process

of influential church leaders in October. FEMEC will be in a position to take advantage of all the inputs the project will provide.

V. AID Contractors

A. For MCH/FP project

While all four of the contractors which will have responsibilities under this project have already begun implementing family planning activities in Cameroon, some have a longer experience at it than others. All the contractors have already gone through the AID competitive bidding process (and have contracts with S&T/POP) and USAID will use the buy-in mechanism to procure their services under this project.

1. SEATS

The Family Planning Services Expansion and Technical Support Project has been working in Cameroon since 1990. Short-term technical assistance from the regional office based in Lome, Togo and the SEATS headquarters at John Snow, Inc., in Arlington, VA has been provided to perform initial needs assessments, organize contraceptive logistics training, and begin supplying contraceptives to a limited number of centers.

SEATS will be the lead contractor under this project. Its duties will be to provide a long-term technical advisor to work in the DFMH to oversee implementation of the public sector component of the project, plan the expansion of child spacing services throughout Cameroon, and reinforce the PHC management system. SEATS will also provide a long-term technical advisor to work in the private sector to assist in promoting the expansion of child spacing services through the non-profit and for profit private sectors, especially the existing Protestant hospitals. SEATS will provide for all the clinical training in minilaparotomy, will procure contraceptives, and will deliver contraceptive logistics training for the private and some of the public sectors.

SEATS is a relatively new project in AID/W and is in the process of establishing its reputation in delivering family planning services through its contract.

2. PAC II

The Family Planning International Training in Health Program has just begun family planning activities in Cameroon. It will be responsible for developing the medical standards and service delivery protocols which will be adopted and used nationwide. INTRAH will provide all the clinical training for the public sector, which includes the development of the training modules for the child spacing/maternal health program.

Although PAC II has just started activities here, they have a long history of providing high quality training in health in Africa. INTRAH has also been working in other countries with some of the contractors who will be involved in this project. INTRAH has a regional office in Lome, Togo.

3. PCS

Population Communication Services (PCS) will assist the DFMH to implement a national information education and communication program for child spacing/maternal health. It will

begin with the development of a plan, train trainers to develop test and refine messages, materials and campaigns and will assist in the distribution of IEC materials to service delivery sites and in the IEC campaigns for child spacing in the areas surrounding service delivery sites. PCS is represented in Cameroon by an IEC specialist.

4. JHPIEGO

Johns Hopkins Program in Education and Reproductive Health has been active in Cameroon for several years, and is especially familiar with the CUSS division with which it will work over the course of this project. It will continue to work with CUSS to strengthen the reproductive health curricula for CUSS and CESSI by developing modules, testing and evaluating them, providing audio-visual materials, and some equipment and supplies for the schools.

In addition, JHPIEGO will work with professors at CUSS to conduct medical research to test the effects of Norplant on Cameroonian women.

JHPIEGO will provide short-term technical assistance as required to assist CUSS and the DFMH's Training division in these activities.

5. PSI

Population Services, International has been managing a condom social marketing program in Cameroon since 1988. It provides a long-term technical assistant to a private firm in condom marketing and distribution. The project will procure all condoms for PSI.

B. Other USAID Health Contractors

1. MCH/CS (HIID, AED, DREW)

USAID's MCH/CS project (SESA) is implemented by a consortium of three contractors: Harvard Institute for International Development, the Academy for Educational Development and Drew University. Began in 1987, this \$11.5 million project is implemented through the DPRM in two provinces: South and Adamaoua. SESA has four long-term technical assistants: the Chief of Party, IEC/Training advisor (currently vacant), and a coordinator in each of the provinces the project covers.

The project purpose is to implement the reoriented PHC program in the South and Adamaoua provinces. This project will be heavily relied upon to assist the MOPH implement integration of the child spacing component into the two target provinces. This project, because it is implemented through the DPRM, will be key to coordination of activities with the DFMH. Plans are already made for the training of the child spacing component under the SESA project, and integration of child spacing services with the additional inputs the child spacing project will provide.

2. Save the Children

Save the Children Federation is implementing a health program which is village-based in two departments in the Extreme North province. SCF has its headquarters in Maroua, the provincial capital and another office in Doukoula. It implements a series of project, from health to village water supply and community development. With the introduction of the reorientation, SCF is providing assistance in the two departments where it works to sensitize

communities and to train arrondissement level MOPH staff in reorientation. In addition, SCF has a Population Council operational research grant to test IEC on acceptability of family planning. This activity has put traditional midwives in a position to sensitize village communities, lead discussions on family planning, and teach about the various methods. Save the Children has one expatriate director in Maroua, a full staff in Maroua and Doukoula and a skeleton staff in Yaounde.

3. CARE

CARE implements a village health program in two departments of the Extreme North province, where traditional birth attendants and village health workers are trained. CARE has a regional office and full staff in Mokolo to administer this and other projects. CARE may be involved in implementing the reorientation of PHC program in the two departments where it works.

VI. USAID

A. Project Management

The project will be managed by the HPN officer with technical assistance from a Personal Services Contractor who will be hired under the project. Other Mission offices will have major responsibilities in implementation and monitoring, especially the Controller's office, the Project Development and Evaluation office. The HPN office will undertake design of a second phase MCH project in 1992. This project is a logical extension of FHI II which also had several contractors through buy-ins to centrally-funded projects, so will not be an inordinate management burden on the HPN office with its present staffing.

B. Coordination

As one of the major donors in Child spacing/maternal health in a country which only recently backed away from its natalist policy, USAID will have to keep its finger on the pulse of policymakers in health. The challenge will be to make strides in couple years of protection, contraceptive prevalence and general acceptability of child spacing without pushing too hard and engendering a backlash. One of the effective ways to meet this challenge is to meet regularly with other donors in child spacing and appropriate government, religious and traditional leaders to sensitize them and to be sensitized by them.

VII. Conclusion of Administrative Feasibility

Although there will be four government offices responsible for different aspects of project implementation (DFMH, DPRM, CUSS, Provincial teams), they already work together on many different aspects of primary health care. This child spacing activity will be integrated into the ongoing activities. The project directorate will be in the DFMH, with the director being responsible for coordinating all activities on the government side. Under a buy-in to the SEATS project, a resident advisor will be assigned to advise on strategies and plans for integrating child spacing into the PHC and to advise on coordination of all family health/child spacing activities within the ministry and among donors. A resident advisor for the private sector will also be made available to provide technical assistance for expanding child spacing activities there.

With this and the short term assistance for training and consulting which the USAID contractors will supply, the national implementing agencies will be able to properly administer and manage this intervention, provided they consider coordination among themselves and with other donors to be key to a successful program.

Financial and Economic Analysis

I. Introduction

The principal objective of the following analysis is to assess whether the family health program activities supported under the project will be financially sustainable after the end of project. This assessment starts with a review of recent economic trends and the implications of these for the financial well-being of public and private sector health services providers in Cameroon. The analysis then identifies what will be the on-going recurrent costs of project activities. The approach of integrating family health services into the current system of public and private providers is considered to minimize the recurrent costs of project activities. Information is then reviewed about the prospects and possible limitations of cost recovery systems for rural health services in the public sector. Information is presented of relevance to assessing the financial sustainability of project activities in private, non-profit and for-profit institutions. The financial viability of the social marketing program is considered through review of three scenarios for future sales volumes for CSM products. The annex concludes with a review of information of relevance to consideration of questions as to whether: i) project benefits exceed project costs, and ii) project interventions achieve the project's goal and purpose by the most cost-effective means.

II. Background Information

A. Trends and Prospects for Cameroon's Economy

The Republic of Cameroon experienced relatively rapid economic growth throughout the 1970s and into the mid-1980s. Growth was led by export earnings from agricultural products, principally coffee and cocoa. During this period, gross domestic product (GDP) increased at an average annual rate of 5.2 percent from 320 billion FCFA in 1970/1 to 1,800 billion FCFA in 1980/1. The substantial expansion of oil production beginning in 1978 further accelerated growth of GDP to 9 percent annually from 1980/1 to 1985/6.

Since 1986, Cameroon has endured an economic recession which has resulted in an estimated 21 percent decline in real GDP. The drop in the world price for oil in 1986, and the subsequent steep reduction in the world prices of cocoa and coffee, beginning in 1987 and continuing up to the present, have cut export earnings by almost one-third.

Beginning in early 1988, the Government of the Republic of Cameroon (GRC) began discussions with both the IMF and the World Bank regarding the stabilization and structural adjustment of its economy. With the support of a Stand-by Agreement approved in September 1988, and a Structural Adjustment Loan approved in July, 1989, the GRC began to undertake actions aimed at: i) curtailing the growth of public expenditures; ii) strengthening and broadening revenue collection; iii) reforming the civil service; iv) liberalizing trade; v) liquidating, privatizing, and restructuring the parastatal sector; and vi) restructuring the commercial banking sector.

In spite of initiating fiscal and administrative reforms, USAID's Cameroon Action Plan FY 1990-1992 concluded that:

"...there is little cause for optimism regarding the Cameroonian development environment. This environment is an extremely difficult one, in which maintaining zero growth should be viewed as a very significant accomplishment. By 1993-94, assuming the validity of the "slow recovery" scenario, the majority of major economic indicators will be at similar levels to those during 1983-85."

The current economic crisis which the GRC is experiencing has led during the last 3 years to a significant reduction in per capita income and the private consumption of goods and services. In addition, in its effort to significantly reduce the public sector deficit, the government has curtailed grants to the social sector in such fundamental domains as health and education. The economic downturn and resulting Structural Adjustment

program has also had an overall negative impact on employment. In response to the negative effects of the crisis on the population, the GRC, in collaboration with multilateral and bilateral donors, developed the Cameroon Social Dimensions of Adjustment (SDA) program. The principal objectives of this program include:

- o Short to medium term protection of the disfavored and vulnerable segments of the population, particularly groups directly affected by the economic crisis and the adjustment program;
- o Short to medium term participation of poor groups of the population in the process of recovery; and
- o Direct assistance to the health sector.

B. Trends in Government Financing for Health Services

Although GRC budgetary allocations for health grew during the 1970s and early 1980s, they did not grow as fast as overall government expenditure. Consequently, government budget allocations to the health sector declined from approximately 6.0 percent of government expenditure in 1968/9 to 4.1 percent in 1990/1. In addition, the economic crisis has necessitated a cut in overall government expenditure resulting in a decline in health sector expenditure in nominal terms from 27.8 billion in 1986/7 to 22.8 billion FCFA in 1990/1.

The GRC investment budget for the health sector totaled 2.6 billion FCFA during the period 1981 to 1985. Investment spending increased markedly in 1986 to 23 billion FCFA, and remained roughly at this level until 1989. Most of this investment expenditure was allocated to hospital construction, with 14% being allocated to the construction of primary health centers. Investment spending declined again in the 1989/90 and 1990/1 budgets, representing less than 1 percent of the GRC's investment budget.

Personnel costs currently account for about 80 percent the GRC's recurrent budget for the health sector, with the remainder allocated for drugs and other expendibles¹. Actual expenditure for non-personnel inputs may in fact be lower, (e.g. in 1989/90, 2.1 billion FCFA (193 FCFA per capita) were allocated for drugs, although actual expenditures amounted to only 200 million FCFA (37 FCFA per capita).

C. Policy Environment Regarding Health Care Financing

In response to the decline in government financing for health services, the MOPH introduced a new vision of a comprehensive PHC system when it declared the "Reorientation Approach to Primary Health Care" in 1989. Improved health delivery was to be achieved through decentralization and fueled by community based financing. The cost recovery approach was put forth by the MOPH as the means by which to achieve previously unmet health objectives during a period of economic hardship. While the government has stated that cost recovery efforts are meant to supplement government recurrent budget allocations for the health sector, not replace them. In reality, however, this is a promise which is difficult to keep during a period of macroeconomic decline, and it is likely that government financing for the health sector will continue to decline in real terms. The reoriented PHC system is designed to target government resources to specific inputs (e.g. personnel, central supervision), and cover other costs (e.g. pharmaceutical supplies, health center and district supervision) through community financing.

While the idea of cost recovery through drug revolving funds is the basis of the much publicized "Bamako Initiative", a strong base of support exists in the MOPH in Cameroon for a reoriented approach to PHC (of which community financing plays a key role) since it has been established by the MOPH as a part of its health

¹This can be compared with the allocation of expenditure in protestant mission facilities: personnel - 52%, medicines - 22%, other - 26%.

policy, rather than an economic policy imposed on it by other Ministries or donors. A great deal of openness has been demonstrated towards permitting various pilot experiences in implementing the reorientation approach. At present, approximately one half of the country is, or shortly will be, contributing financially towards obtaining their health care at public facilities.

Recent legislation² has permitted health facilities to charge patients for drugs dispensed and retain the fees in order to restock the facility³. This has enabled health facilities to ensure their resupply of drugs. A proposed amendment to the 1990 law which permits health facilities to charge for consultations and reinvest revenues in facility operations is currently under discussion. While the MOPH has strong commitment to the policy which includes cost recovery mechanisms, several legal changes remain to be promulgated which would permit the system to be implemented nationwide.

D. Willingness and Ability to Pay

Health sector cost recovery strategies assume that populations served by the facilities are able and willing to pay for their health care. There is a wide body of literature in the field of health economics which indicates that the demand for health care is price inelastic, and it is based on these studies that international donors have encouraged countries to embrace user fees.

Cameroon benefits from an average per capita income of \$970 (1989 World Bank estimate), a sum well over double many of its African neighbors, including those that have had positive experiences with health sector cost recovery⁴. A study completed by the Ministry of Planning in 1983 found that the average household in Cameroon spent 5,726 FCFA (\$22) per year on health care⁵. Average expenditure was lower in the proposed Cameroon National Family Health Project provinces (e.g. South - 4,773 FCFA (\$18.35), and Adamaoua and Extreme North - 2,336 FCFA (\$8.98))⁶. An October 1990 household survey, administered to 768 households in Adamaoua⁷, found that the average expenditure per episode of illness was 4,393 FCFA (\$16.90)⁸. The

²Law No. 90/062 decreed December 19, 1990.

³The government has permitted hospitals to charge fees for services since June 9, 1962 (Law No. 62-6). Details of medical fees were further outlined in a presidential decree of April 24, 1973 (Decree No 63/140) when specific services for which fees could be charged were defined as consultations, laboratory and radiology examinations, dental care, and medical/surgical acts. Fees were implemented by the patient purchasing a stamp which was then affixed to his medical record. Revenue raised through the sale of stamps was divided between the medical specialist (who was entitled to a fixed percentage of each service) and the Ministry of Finance. Revenue was not reinvested in the operation of the health facility.

⁴Per capita statistics can be deceiving because they are based on aggregate national wealth divided by total population. In reality income distribution is generally very skewed with most of the population earning less than the average. Moreover, in Cameroon almost half of the population is urban based and thus the average per capita income reflects a heavy weight from the higher earning urban population. The rural population could well have an average income well under the national average.

⁵While it is true that household income in 1983 was boosted by the strong economy, it was also a period when people needed to spend less on health care since the public health facilities were well supplied with drugs and supplies and were zero priced. The fact that even then they spent considerable amounts on health care indicates an ability and willingness to pay for preferred care.

⁶Enquete Budget-Consommation Aupres des Menages - Septembre 1983-Septembre 1984: Principaux Resultats sur Les Depenses Monetaires Des Menages au Cameroon", Ministere du Plan et de L'Aménagement du Terriroire, Direction de la Statistique et de la Comptabilite Nationale, Feb. 1987.

⁷Jennie Litvack for Projet SESA "The Effects of Co-finance Activities on Health Seeking Behavior and Health Care Expenditure", ongoing research.

average amount paid per episode of illness was 671 FCFA (\$2.58) for transportation, 2,133 FCFA (\$8.20) for medications, and 1,589 FCFA (\$6.11) for consultation⁹.

While these findings demonstrate that households in Cameroon do pay for health services, it should be noted that the reoriented PHC program with its "co-finance" (cost recovery) component is being introduced in the country at a time when the country is suffering from its 3 year old economic crisis. Though most of the population may indeed be able and willing to pay for health care, overall health center utilization - at government, mission and private health facilities - has declined quite dramatically since 1988 and particularly since 1989. While government facilities in some provinces (e.g. Adamaoua and South) attribute their low utilization rate to lack of supplies during this period, the decline in utilization of government facilities in areas where supply has been steady (e.g. North-West) and in the confessional and private sectors suggests that other factors may be associated with the decline in health facility utilization.

It would be reasonable to assume that a portion of the decline in health facility attendance is attributable to the economic crisis. This indicates that when income levels change people are sensitive to increased costs (direct health costs, indirect opportunity costs and access costs of transportation, gifts, etc.) With real incomes declining during the economic crisis, constant prices represent a greater portion of a household's income.

USAID, in its FY 1990-92 Action Plan, indicated that:

"Reflecting the uncertain economic environment, the climate for policy change is decidedly mixed. At one level, the GRC is highly receptive to reform because they see the need for change. ... the lack of cash in the economy (IBRD estimates liquidity in the rural sector has been reduced 40%) is depressing demand just at the point that we are encouraging the GRC to promote privatization."

The health sector must try to weather the economic crisis by providing the most cost-effective services possible to the greatest number of people. The "reorientation approach" to PHC is one way that the MOPH is attempting to do so. However, the financial stringencies faced by the government and households may necessitate revision of cost recovery targets, and/or greater donor commitment for aspects of the PHC co-finance system until Cameroon's economy resumes growth.

III. Financing the Recurrent Costs of Cameroon National Family Health Project Activities in Government Health Facilities

A. Integration of Family Health Services/Supplies in the PHC System

The PHC system has recently been redesigned in a manner which both the MOPH and USAID (through its MCH Project SESA) believe to be the most effective and sustainable possible. Much emphasis has been placed on designing a system through which all health care activities can be delivered and supervised and most can be financed. There are several key components to the PHC system including curative care, child spacing and growth monitoring, malaria control, nutrition, immunizations. The Cameroon National Family Health project will provide IEC, training and commodities to permit special emphasis on some components of this PHC strategy.

⁸Health care expenditures represented amounts paid for consultation and/or remedies at public or private health centers or hospitals, pharmacies, traditional healers, or at the market place and transportation costs incurred to obtain care.

⁹These are averages; many people obtained care for free while many others paid varying amounts. This does not indicate if most people could or would pay the "average" expenditure.

At least three strong arguments can be made for integrating the family health project into the existing PHC system:

- o The PHC system has been designed to emphasize continuity of care, an essential component of family health.
- o The community finance and management mechanism which permits the center to raise funds to replenish supplies and permit outreach activities is being established and will require no additional financial input from the Cameroon National Family Health Project. Developing this mechanism has involved: i) training in financial and logistics management of pharmacy clerks, ii) community health and management committees and district supervision teams; iii) the development, printing and use of financial control forms and procedures; iv) the development of a financial management information system; and v) the development of a co-finance supervision checklist.
- o The costs associated with the logistics system, regular supervision schedule, and programmed refresher training sessions are already included in the revenue targets to be realized through the established consultation fees and drug prices. For example, supervision at both the district and health center levels is assured by charging mark-ups at the district and provincial level drug depots which permit 4 annual provincial supervision visits to the district and monthly district supervision visits to the health center. By including these necessary support services into the prices paid by the community, their sustainability is greatly enhanced.

Most of the proposed activities to be supported under the Cameroon National Family Health Project constitute the investments required to integrate family health activities into the PHC system. The on-going provision of these family health services within the PHC system will generally result in small, marginal costs, and it is intended that these will be covered by fees paid by the community as is intended to be the case for other service provided by government health facilities. Table I provides a listing of all the categories of investment and recurrent costs under the Cameroon National Family Health Project. The marginal recurrent costs of integrating the family health activities into the PHC system will, for the most part, be minimal.

o Supervision: District supervisors will visit the health center each month. The purpose of the supervision visit will be to complete a routine check on a number of clinical and managerial issues and then complete a more focused supervision on a special clinical issue each visit. Family health issues will be included in the monthly routine check list and a special supervision focus session on family health can be planned. All costs associated with this trip (i.e. motorcycle fuel, supervisor travel time, amortization of the motorcycle) would already be incurred through the PHC system. Given that the fixed costs associated with supervision are the major financial burden, supervision of family health activities during the supervision visit will not impose significant additional recurrent costs.

o Logistics: The provincial teams involved in the PHC areas will be able to order contraceptive supplies as they do drugs. Requests for drug or contraceptive supplies will originate from the various depots and then the provincial team will call or fax the supplier and request specific quantities of needed items. Items delivered to the provincial level will then be delivered to the depots or picked up by the depot in the provincial capital. Health centers travel to the depots and purchase their needed supplies. The marginal transportation costs of adding the distribution of contraceptives to this system would be close to zero, and the average cost per item for transportation would decline.

o Training: All Cameroon National Family Health Project training occurring during the life of the project will be funded by the Project. Refresher in-service training for family health will be included in the annual PHC refresher training programs. The marginal recurrent costs of adding a family health module to the 3 day refresher training course would be the additional time spent away from their work, and perhaps another day's per diem if the time scheduled for the session required another complete day. Since two staff

at each health center will attend refresher training and the per diem is 5000 FCFA/day, the marginal recurrent cost of one more day of training would be 10,000 FCFA for each health center. Considering the PHC refresher training program is already structured and will be financed through the community financing (consultation and drug fees), the marginal cost of adding the family health module to the refresher training course is again minimal.

While refresher training can be provided in conjunction with the PHC refresher training, new in-service training courses in family health will need to be conducted periodically (perhaps every two years) to train MOPH personnel relocated to a project area. While in-service training for the existing personnel in the project areas can be completed over the LOP, Cameroon's public service suffers from an extremely high rate of relocation. While relocated personnel will receive training in the PHC training course, and a family health component can be added to this course, this training session requires more time than most other modules. Costs of in-service training under the project are estimated at US\$ 2,000/participant (580,000 FCFA). Given the magnitude of this investment expense in light of the limited availability of government resources, the recurrent costs of periodic continued in-service training would be a good candidate for donor funding. If donor funding was not forthcoming, this recurrent cost would not be incurred until after the project, or at least 1995; by this time it is expected that the economy will have resumed positive economic growth. The cost of this periodic in service training course to relocating MOH personnel represents the largest recurrent cost that the Ministry may have to incur as a result of this project; but it is likely that donors could support this cost.

Other recurrent costs of inputs of the Cameroon National Family Health Project are the replacement costs of equipment. However, the equipment is relatively inexpensive and long lasting. The only piece of equipment which may require maintenance is the laparoscope. If there are parts which fail after a period of time, the project may be able to foresee this problem by providing a stock of this replacement part, or at the very least procure laparoscopes for which replacement parts can be obtained in Cameroon or imported without difficulty. It is likely that donors may also be able to cover these costs.

IV. Financial Viability of the PHC System

Since the Cameroon National Family Health Project will be integrated into the newly "reoriented" PHC system, successful implementation of the project will depend on the ongoing success of the PHC system. Therefore, it is necessary to assess the financial viability of the PHC system.

A. Financial Responsibility of Government, Community, and Donors within the PHC System

The PHC co-finance system became operational in January, 1991 when after several months of financial and logistics management training, village sensitization, and procurement, drugs arrived at health facilities. A consultation fee of 200 FCFA was introduced to cover outreach activities and improvements in the health center. Prices charged for the drugs represent the local replacement cost of the drug item, plus a mark-up which covers other costs associated with the operation of the PHC system. As a result of all these costs to be covered by the community, the mark-up placed on the purchase price of all drug items sold to patients is 160% (e.g. an item which is procured from the supplier at 100 FCFA is sold to the patient at 260 FCFA). The list of items to be covered by the drug mark-up and the consultation fee was established after discussions with MOPH. Categories of recurrent expenses for which MOPH, Donors and the community are responsible appear in Table II.

The current list of items to be covered by the community is very comprehensive for a cost recovery program. As a result, the total price asked of the population is also quite high. Since the co-finance activities are part of a newly invigorated PHC system, other costs associated with PHC are incorporated into the revenue objectives. While the PHC system was designed to ensure sustainability by limiting reliance on the government, less ambitious cost recovery targets may need to be set for the near future until the country comes



out of its economic crisis. Donors may have to step in to provide support for some of the costs that were to be community supported. For example, costs of supervision and maintenance are being supported by USAID during the first 9 months start-up for each health facility. The length of this period may need to be reconsidered. Alternatively, line item costs may need to be modified (e.g. reduce supervisory visits). Top priority items to be covered through cost recovery are: i) restocking the drugs; ii) covering the pharmacy clerk's salary; and iii) basic health facility supervision.

B. Illustrative Example of Recovering Costs at the District Level

Costs to be covered by the community are included in the calculation of drug prices. Drug prices include the replacement costs of the essential drugs plus a mark-up established to cover the costs associated with each level of the drug distribution system. Some of these costs are a function of the number of health facilities, population size and utilization rate. The following is an example from South Province.

At the provincial level, drugs are procured from the supplier and then sold to the depot at their cost price plus a mark-up which reflects costs incurred at the provincial level. These include: the salary of the storekeeper, per diem for 4 inspection tours per year, one annual provincial board meeting, administration, utilities, vehicle and building maintenance, pharmacy workshop, refresher training, drug expiration or theft or pilferage, consumer goods, printing forms, and stationary. The total value for these costs is covered in the South province through a mark-up of 61% on drug items imposed by the province on the intermediate depot.

The following costs are incurred at the intermediate depot level: storekeeper salary, per diem expenses when drugs must be picked up from the provincial level, administration, utilities, building maintenance, maintenance of cold chain, expiration or theft or pilferage, consumer goods and stationary. The cost of these items are covered through a 16% percent mark-up on the price of drugs sold by the depot to the health centers.

At the health center level, the following costs are incurred: salary of pharmacy clerk, per diem for health center staff conducting outreach activities, maintenance of motorbikes and buildings, transportation to depot to obtain drugs, PHC refresher training, maintenance of cold chain, expiration or theft or pilferage, consumer goods and stationary. These costs are covered in the South through a 83% mark-up from the price paid to the depot to the price paid by the patient. In total, the patient pays a 160% mark-up over the original purchase price of the item (see Table III).

Although all the above mentioned costs associated with this drug distribution/PHC system are to be covered ultimately by the community, a critical minimum number of patients are necessary in order to raise revenue to cover the health center's fixed costs associated with the system. Revenues are generated through drug sales, consultation fees, maternity services, preschool and prenatal consultations, and wound dressings.

Regardless of patient volume, costs such as the pharmacy clerk's salary, supervision, refresher training, motorcycle maintenance, and maintaining the cold chain must be met. The estimated total of fixed costs per health center is 84,350 FCFA (US\$325) per month. Health centers in the South would break-even at 63 new cases per month. If we assume a health center utilization rate of 25 percent of the population with one new case a year¹⁰, 63 new patients requires a catchment area of 3000. The sensitivity analysis in section 5 of Table IV indicates the financial position of health centers located in areas varying in population size (see also graph 1).

¹⁰Based on Projet CIM data from 9 health centers in the Extreme North.

C. Assumptions Underlying Co-financing of the PHC System

Several key assumptions underlie the viability of the co-finance PHC system.

1. **The availability of drugs and supplies will attract a sufficient number of patients to the health center to cover the fixed costs of the system.**

Low health facility utilization has been attributed to the lack of supplies and drugs available. A recent household study in Adamaoua found that 24% of ill people who did not go to the health center indicated that the lack of drugs was the reason for not attending¹¹. By making drugs available (even at a price) it was assumed that people would be attracted to the health center.

2. **Drug supply will be procured at a price sufficiently low to enable mark-ups to cover designated fixed costs and outreach activities and still attract patients.**

Given the ambitious list of items to be covered through community financing, the base price of the drug would have to be very low to enable the various other mark-ups and still be competitive (preferably less expensive) than other local suppliers. If health center prices are higher than prices of other available sources, people would be expected to choose to obtain their drugs at the lower priced source.

3. **Most of the population in the rural areas is willing and able to pay.**

Even when drugs are procured at a sufficiently low price which permits designated mark-ups and results in a competitive price, if most of the population is not willing and able to pay that sum then fixed costs may not be met, or health objectives may not be achieved. Developing a PHC system which depends so greatly on community participation assumes that the population will support the system through its patronage and financial contributions.

D. Factors Which Influence the Strength of the Above Assumptions

1. **Health facility utilization rate is low in areas with low population density.**

The co-finance PHC system is being introduced in health center catchment areas whose population varies from 2000 to over 10,000. In order for Assumption #1 to hold, a minimum number of consultations must occur in order for fixed costs to be covered. Since utilization usually reflects the catchment area population size, fixed costs will be more difficult to cover in some areas than others. If an annual per capita utilization rate of 25 percent is assumed, a minimum population area of 3100 would be necessary to cover the costs of a health center (see graph I). In areas with less than this number of inhabitants, a higher rate of utilization would be necessary to cover fixed costs. Conversely, if the utilization rate were considerably lower, then even in higher population areas fixed costs may not be met.

2. **A reliable local supplier of essential drugs is unavailable.**

As per Assumption #2, a reliable low priced supplier must be used in order to permit mark-ups and still be competitively priced. Ad Lucem is currently being used as the local supplier for the public sector. While Ad Lucem is currently the most reliable, and lowest price, supplier in Cameroon, other sources are being explored. The MOPH is reviewing their policies regarding the future of a national pharmaceutical supplier. ONAPHARM, currently the government's parastatal pharmacy, has been unable to reliably provide drugs to

¹¹Jennie Litvack for Projet SESA, "Health Seeking Behavior and Health Expenditure", ongoing research.

the public sector. THE MOPH may restructure and recapitalize ONAPHARM. In that case, co-finance provinces should have the option of resupplying with ONAPHARM or with other domestic pharmaceutical suppliers.

3. Rural Population Becomes Increasingly Unable and/or Unwilling to pay.

Two factors could jeopardize the present situation with respect to the population's ability and willingness to pay for health center services. First, if the economic crisis worsens and household disposable income is further reduced, access to health care could be threatened as ability and willingness to pay declines. This is a serious concern as health facility utilization patterns over the past few years have indicated the strong income elasticity of health care.

Second, if the currently overvalued FCFA were devalued the price of imported drugs would effectively increase. Resupply of drugs would occur at higher prices and this would need to be passed onto the consumer (patient). This may well exceed the population's willingness and ability to pay and prove too high a price to pay.

E. Aspects of PHC Design Which Strengthen Chances for Sustainability in an Uncertain Macroeconomic and Political Environment

1. Limited reliance on government for health center recurrent costs.

Since in recent years the government has proven to be unreliable in terms of meeting various recurrent cost commitments in the health sector, the PHC system has been redesigned to target government resources to specific items, such as personnel costs. The community is now responsible for covering such costs as pharmaceutical supplies, supervision, vehicle maintenance, fuel for outreach activities, maintenance of cold chain for vaccines, and salary of the pharmacy clerk. However, the level of cost recovery expected of the community may be too ambitious for the economic circumstances of Cameroonian households at this time. Should the preliminary results of the SESA project co-finance efforts (available in July, 1991) indicate that the proposed levels of cost recovery are too high for the community to support, line items amounts could be strategically reduced to ensure that the most essential items are covered.

2. Community Health Committee Provides Flexibility for Solidarity.

The macroeconomic situation could continue to worsen or the FCFA could be devalued making the price incurred at the health center represent a greater portion of the household budget. While some households will be able to increase their health budget, other households may not and might normally be forced to reduce consumption. The percentage of the population considered "indigent" may increase as available resources decline. The PHC system has been designed, however, to have the capacity to respond to community specific problems through the creation of a Community Health Committee at each health facility. This health committee is responsible for all non-clinical decisions affecting the health center and its catchment population. Each health area forms a this committee consisting of elected representatives from each village covered by the health center.

The health committee determines priorities and policies of the health center including such issues as the definition of, and provision of services to, indigent persons. Because the community feels ownership in the new system (i.e. it is "their" health center) they are encouraged to decide amongst themselves how to solve such problems as lack of liquidity amongst some of its population. The health committee has the flexibility to

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decide to use a portion of health center "profits"¹² as a pool for members of the community unable to pay the health fees, or to devise some community specific solution. For example, one health committee president in the South Province recently explained how he and other prominent members of their community would pay the health center bills of very poor, and in turn, they would work on his and his colleagues' farms until their health center bill had effectively been paid off¹³.

3. Proposed Full Fee Retention at Health Facility Level Prohibits Government from Drawing on Community Resources at Central Level.

The government has stated that contributions from the periphery to the center will be equal to zero. Adoption of this policy is important since experience in other countries has indicated that the success of cost recovery experiments is poorer when revenues are not reinvested locally to assure quality improvement¹⁴.

4. Possibility of Using Pricing Strategies to Promote Use of Cost-effective Medications and Contraceptive Supplies.

While the initial pricing strategy used in the co-financed health facilities is based on a flat mark-up of all products, this strategy is being revised to include a system of cross-subsidies. The new pricing strategy will achieve revenue targets by charging larger mark-ups on the less expensive and the less critical medications and lower mark-ups on the more expensive and more vital drugs¹⁵. Development of a pricing strategy which encouraged users to adopt and use the most cost effective methods of contraception could also be employed. Experience in other countries has shown that choice of method is influenced by the price of the method. With this method of pricing, the discount rate (or time preference of money) is considered when pricing the various alternative contraceptives. For example, since oral contraceptives require only one month of payment at a time it often seems more attractive than another method (like injectables) which require spending a greater sum of money at the present time but which provide protection for three months at a lower average monthly cost. If the discount rate is included in the price of the various methods, then people will have the option of using any of the available methods but will be encouraged through price incentives to use the most cost-effective methods¹⁶.

¹²Profits equal revenue generated from drug sales and consultation fees minus restocking and pharmacy clerk costs. Supervision and training expenses are deducted through the depot mark-up.

¹³Based on interview with Health Committee President at Olamze health center on March 12, 1991.

¹⁴For a full description of lessons learned from 10 countries experiences with pharmaceutical cost recovery, see Blakney, Litvack and Quick, "What Experience Tells Us: Financing Primary Health Care Through Pharmaceutical Cost Recovery", prepared by PRITECH for USAID ST/POP, 1989.

¹⁵For a description of this pricing strategy see, Litvack, Shepard and Quick, "Setting the Price of Essential Drugs: Necessity and Affordability", The Lancet, August 12, 1989.

¹⁶The success of using price incentives to encourage the most cost effective contraceptive methods has been documented in Thailand. See Myers, C., Ashakul, T. and Wattanalee, S. (forthcoming) "Contraceptive Repricing Experimentation in Supanburi, Nakhon Sawan, Nakhon Sri Thammarat, and Surin".

V. Private Sector Component

A. Confessional (Mission) Sector

The Family Health Support Project will provide training in family health, MCH equipment and drugs, and contraceptives and child spacing forms to health facilities operated by the missions over the LOP. Mission health centers and hospitals will be phased into the project annually and by the end of the project, 60 of the 92 mission health facilities will be covered by the project. Recurrent costs to be generated by these investments include: i) replacement cost of MCH equipment, ii) provision of contraceptives, and iii) provision of child spacing forms. Refresher training and on-going in-service training will be another recurrent cost that the missions themselves (through their combined channels of resources) would fund. These activities will probably be required with a lower frequency in the mission than in the public sector due to less staff relocation and the presence of qualified expatriates at the facilities for long periods of time.

It is expected that the above recurrent costs will be supported through the combination of community financing and external church subsidies which have historically permitted the confessional sector to cover its operating costs. Mission facilities have existed in Cameroon since the 1930s. Thus, the population has long expressed their ability and willingness to pay for mission health services because of their perceived quality. Revenue from user fees covers about 80% of non-expatriate personnel recurrent costs¹⁷. The combination of revenue from user fees and external sources has generally been sufficient to support the recurrent costs of mission facilities and there is little reason to believe that this will change in the foreseeable future.

B. Private, for-Profit Sector

The project will invest in developing child spacing information and services in health clinics of large businesses and large private for-profit clinics. The investment costs will be to sensitize managers, provide child spacing equipment, and start-up supply of contraceptives, IEC materials and child spacing forms, to train private practitioners in a four-week technical course and to train selected hospital based doctors in mini-laparotomy.

The recurrent costs generated from these activities will be covered by the private health facility directly and by the patients indirectly. Recurrent costs include replacement cost of equipment, repurchasing of contraceptives, child spacing forms, and IEC materials.

Refresher and in-service training to other private practitioners is an additional recurrent cost which could be born by the MOPH. However, new practitioners entering into private practice will, in the future, have been trained in these techniques (if educated in Cameroon). Further, since private practitioners tend to stay in the same post for much longer periods of time than MOPH personnel, the need for ongoing in-service training will be less urgent than in the public sector.

Private medical practices, like all businesses, have been hit by the economic crisis. One doctor who operates a large private clinic in Yaounde stated that he earns 8% of what he earned in 1986. The number of his daily consultations has declined by 60% and he has lost his three main corporate clients. In response to the decline in his activity he has reduced his costs by dismissing one of his nurses. Since private medical practitioners can cut back on their short-run fixed costs (e.g. personnel) they are better able to respond to diminishing revenues than many other types of firms.

Private corporations that provide their own health services have found it increasingly difficult to provide health benefits to their workers since their revenues have been declining due to the economic crisis. The Cameroon

¹⁷Awantang, F.N. (July 1983) The Private Sector in the Provision of Health Services in the United Republic of Cameroon, p. 14.

Development Corporation (a government parastatal) operates its own health system consisting of three hospitals and 19 clinics. Due to falling receipts of the CDC, liquidity is a problem and providing free health care for its 16,000 workers and their dependents (totaling 80,000) has become impossible. A recent solution to this problem was to deduct a flat fee from each worker's salary (the sum depends on their category) to cover various CDC costs including health care delivery¹⁸.

In summary, the financial viability of both private practitioners and private corporations which provide health services have also been adversely affected by the economic crisis. However, the private sector has been flexibly reacting to such changes.

B. Cameroon Condom Social Marketing Program

The Cameroon National Family Health Project will provide condoms to the Cameroon Condom Social Marketing Program (CCSMP) throughout the LOP. The recurrent costs generated from this investment will be the continued repurchase of condoms after the project, advertising, and program management.

During program initiation, the MOPH and USAID decided upon a condom sales price of four for 50 FCFA (4 cents a piece). The cost of production, shipment, and handling of the condoms is in excess of 7 cents a piece. The pricing decision was based on the desire to make the condoms affordable to at-risk individuals for AIDS and STDs (who are generally poor) while assuring a cost recovery element for the program. Pricing studies were conducted by PSI to determine the optimal price.

Several aggressive strategies for increasing revenues are planned including the design and marketing of a "luxury" condom which will cross subsidize the widely distributed "Prudence" condom. The social marketing program has also proposed with separate funds a second "child survival" phase to their efforts which includes the sale of ORS and oral contraceptives. The approach to child survival activities will be to enhance private sector delivery of essential health products by strengthening existing distribution and sales networks and encouraging effective product promotion. The sale of ORS and oral contraceptives are expected to subsidize the distribution of condoms and reliance on donor supplied condoms is expected to decrease over the next several years.

Currently, this Population Services International (PSI) managed project is supported through USAID contributions (a buy-in with AIDSTECH and commodity contributions from S&T/H/AIDS) and private contributions raised through PSI. The CCSMP sub-contracts with HOSPICAM, a local Douala-based health products distribution firm, on a joint venture basis for a variety of services including warehousing, packaging, and distribution. PSI hopes that after the start-up period, the sales volume of Prudence will be sufficiently high as to make this a financially attractive business for HOSPICAM to continue after PSI withdraws.

The long-run financial viability of CCSMP will be a function of the prices and sales volume for all products in the social marketing program. CCSMP proposes to add oral contraceptives and ORS to their product line in the hope of increasing revenue. While preliminary studies have indeed indicated a demand for their products, the CCSMP will be entering untested markets at a time of macroeconomic decline. Thus, three scenarios were developed based on assumptions of different rates of sales volume growth. Under the best case scenario, an annual sales growth on all products of 25% was used to project costs and revenues until 1995. The middle case scenario assumed a annual growth rate of 20% and the worst case scenario used an annual growth rate of 15%.

¹⁸When the employee leaves the company all funds deducted are returned to him (without interest). This access to more resources permits the CDC to determine whether its current liquidity problem will be improved if the interest earned from these sums improves the financial position of the corporation.

Under the best case scenario, with current revenue sources (sales and donor contributions), CCSMP could earn a profit by 1991-92; and could eliminate all donor financial and commodity contributions by 1992/3. The middle case scenario reveals that CCSMP could earn a profit by 1993/4 with present revenue sources and could eliminate all donor support by 1994/5. Under the worst case scenario of 15% annual sales growth, donor support could not be removed, and in fact, more outside funds would be necessary to cover the costs of the social marketing project.

This analysis provides an illustrative example of how the financial viability depends greatly on sales volumes which are difficult to predict. Further study of the financial viability of the CCSMP, and ways to improve the likelihood of the program's future sustainability, will be undertaken in the Fall of 1991.

VI. Project Benefits vs. Costs

Population growth is both a cause and a consequence of economic growth. However, rapid population growth can outstrip economic gains, leading to decreased public and private saving and investment, lower economic growth, and declines in real income per capita. Rapid population growth can undermine government efforts at achieving food self-sufficiency, full employment, and in providing wide access to basic social services (e.g. health and education). Studies of programs in diverse countries have consistently shown that the economic benefits of population programs significantly exceed the costs of the program.

VII. Cost-Effectiveness of Project Interventions

Selection of project interventions has given attention not only to increasing the probability of the financial sustainability of project activities, but also to maximizing their cost-effectiveness. Cost-effectiveness considerations have led project design to provide inputs to private for-profit and not-for-profit institutions generally located in urban areas. It would be expected that the demand for family planning services is greater in urban areas, and that the unit costs of providing services are lower (because of economies of scale), and thus that less will be expended to increase contraceptive acceptance through these institutions. In addition, the project will provide training in provision of all methods, increasing the likelihood that service institutions will be able to provide a method that Cameroonian families will wish to adopt. Finally, to the extent that user fees are established for contraceptive methods, the fee structure adopted will attempt to reinforce women's selection of more cost-effective methods.

TABLE I
INVESTMENT AND RECURRENT COSTS OF
THE CAMEROON NATIONAL FAMILY HEALTH PROJECT

INVESTMENT COSTS

PUBLIC SECTOR COMPONENT

1. Develop Medical Standards and Referral Guidelines
2. Strengthening of Pre-service Training
 - health training for faculty members from nursing schools
 - curriculum workshops for faculty from nursing schools
 - training of trainers courses for faculty trainers at medical and nursing schools
 - evaluation of existing reproductive health modules at medical and nursing schools
 - provision of educational and audio-visual materials
3. In-service Training
 - establish pool of national trainers
 - develop 4 week curriculum
 - training of district level PHC training teams
 - training by district PHC team of health center staff
 - mini-laparotomy training for select doctors
 - provision of technical and reference materials for trainers and service providers
4. Integrated Service Delivery
 - provision of child spacing equipment
 - provision of contraceptives to co-financed health facilities
 - provision of start-up supplies of selected MCH drugs
 - printing of initial supplies of child spacing forms
5. Information, Education and Communication
 - research to develop IEC strategies
 - developing and testing IEC materials
 - inclusion of IEC training in-service training courses
 - developing and implementing a program to train animation workers
 - provision of audio-visual equipment
6. Strengthening PHC Management Systems
 - health management information system
 - applied research
7. Strategic Planning
 - technical assistance

PRIVATE SECTOR

1. Confessional (Mission) Sector
 - provision of child spacing equipment
 - provision of contraceptives over the LOP
 - technical training of health staff in 4 week technical course
 - training of doctors in mini-laparotomy

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- provision of start-up supplies of child spacing forms
 - provision of IEC materials
2. **Private For-Profit Sector**
 - sensitization of managers regarding cost benefit of child spacing
 - provision of start-up supplies of contraceptives
 - training of private health practitioners in 4 week course
 - training of doctors in mini-laparotomy
 - provision of IEC materials
 - provision of start-up supplies of child spacing forms
 3. **Commodity Support for the National Condom Social Marketing Program**
 - provision of condoms over the LOP

RECURRENT COSTS (Group to finance after LOP in parentheses)¹⁹
PUBLIC SECTOR COMPONENT

1. **Develop Medical Standards**
 - No recurrent costs
2. **Strengthen pre-service training**
 - refresher training for tutors (MOPH)
 - replacement cost of educational and audio-visual materials (MOPH)
3. **In-service training**
 - on-going periodic in-service training (at provincial, district and health center levels) due to relocation of MOPH personnel (MOPH)
4. **Integrated Service Delivery**
 - replacement cost of MCH equipment and laparoscopes(MOPH)
 - contraceptive supplies (community)
 - maternal health drugs (community)
 - child spacing forms (community)
5. **IEC**
 - ongoing training of animation workers due to relocation (MOPH)
 - provision of IEC materials (posters, brochures etc.), media
 - replacement cost of audio-visual equipment (MOPH)
6. **Strengthen PHC Management System**
 - refresher training (MOPH and community)

PRIVATE SECTOR COMPONENT

1. **Confessional (Mission) sector**
 - replacement cost of equipment (mission facility)
 - contraceptives after project (community)
 - optional refresher training and in-service training due to normal relocation/attrition of staff

¹⁹While these are the initial groups proposed to cover the various cost categories, adjustments may be necessary during the next few years while Cameroon continues to suffer from its economic crisis.

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(mission staff or MOPH)

- possible in-service training of mini-laparotomy at 3 hospitals (MOPH)
- ongoing supply of child spacing forms (community)

2. Private For-Profit Sector

- replacement of equipment (Private practitioner directly, patient indirectly)
- replacement of contraceptives (patient)
- refresher training and in-service training (MOPH)
- child spacing forms (Private practitioners directly, patients indirectly)

3. National Condom Social Marketing Program

- condoms (clients)

TABLE II
DELINEATION OF RESPONSIBILITIES FOR RECURRENT COSTS
OF PRIMARY HEALTH CARE SYSTEM

MOPH:

- * Salaries of Health Workers
- * Pre-Service Training
- * Supervision from central to provincial levels
- * Production of national MIS reports

DONORS:

- * Contraceptives
- * Vaccines

MOPH or DONORS:

- * Depreciation of Health Infrastructure
- * Depreciation of vehicles
- * Operations Research
- * Health equipment
- * Health education material
- * In-service technical training

COMMUNITY:

- * Salary of pharmacy clerks
- * Per Diem for Logistics Resupply
- * Transport for PHC logistics
- * Administration for cost recovery system
- * Vehicle maintenance
- * Pharmacy maintenance
- * Maintenance of cold chain
- * Transport of vaccine
- * Loss and waste of drugs
- * Motorcycle maintenance
- * Motorcycle depreciation
- * Supervision-subdivision to health team
- * Supervision-Division to sub-division
- * Supervision-Province to division
- * Supervision-Health center to CHW
- * Provincial Emergency fund
- * Expendable supplies
- * Printing of forms
- * Office supplies
- * Refresher training for health workers
- * Essential drugs

TABLE 3:

COST CALCULATION FOR PROVINCIAL DRUG SUPPLY SYSTEM

SOUTH PROVINCE

VARIABLES TO SET:	# of nights/HC sup	1	! note:each HC supervised separately
	# of nights/DIV sup tour	2	! note:all DIV supervised during 1 tour
	# of nights/SD sup	1	! note:each SD supervised separately
	Average # of kms/SD supervision	200	
	Average # of kms/HC supervision	50	
	# of kms/prov trip	1,000	
	# of days/prov trip	6	! note:one trip to visit all int.depot
	# of 4*4wd at DIV	3	
	# of PROV depot	1	
	# of int. depot	3	
	# of DIV. hosp.pharcacies	3	
	# of SD hosp.pharcacies	12	
	# of health centers	49	
	# of vil. health posts	0	

COST DESCRIPTION:

MONTHLY COST BY COST LEVEL IN FCSA

				PROV.	DEPOT	PERIPHERY
SALARY						
1. storekeeper	number					
prov	40,000	1		40,000		
int depot	40,000	3			120,000	
DH	25,000	3				75,000
SDH	25,000	12				200,000
HC	25,000	49				1,225,000
VHP	5,000	0		0		
4. watchman				0	0	0
				0	0	0
				0		
OPF DISM						
1. provincial trips	# PERS.	rate/day	day/trip	# h. fac		
4 trips/y/dep	2	10,000	6		40,000	
2. inspection tour						
1 night/hf	2	10,000	1	55	100,000	
3. depot	4 trips/y/d	1	5,000	2		5,000
4. periphery excluding VHP						
8 drug order/y	1	5,000	2	64		220,000
5. vtp						0
6. audit	0				0	
7. prov. board						
1 meeting/y	1	5,000	2	57	55,000	
ADMINISTRATION						
1. tel, fax, telex	number					
prov	50,000	1			50,000	
depot	10,000	3				30,000

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COST DESCRIPTION:

MONTHLY COST BY COST LEVEL IN FCFA

				PROV.	DEPOT	PERIPHERY
2. post, bank						
prov	10,000	1		10,000		
depot	5,000	3			15,000	
3. water, electricity						
prov	10,000	1		10,000		
depot	5,000	3			15,000	
MAINTENANCE						
	number	cost/vehicle				
1. vehicles	2	50,000		100,000		
2. Motorcycles	15	12,500		187,500		
3. Motobikes	49	5,000				245,000
4. buildings						
prov	5,000	1		5,000		
depot	5,000	3			15,000	
peri	5,000	64				320,000
TRANSPORT						
	#trip/y	km/trip	rate/day	% fac.	rate/km	
1. prov. trips		4	1,000		150	50,000
2. depot trip to prov		4	10,000	2		8,000
incl. trans. costs consig						
3. HC&SDH trip to depot		6	5,000	51		152,500
incl. trans. cost consig						
4. VHP trip to HC (2VHP/HC)		6	2,000	0		0
TRAINING						
1. Phar. workshop for HC&SDH&DH clerks	#attend	#/year	#days/training	Rate/day		
	54	1	3	10,000		150,000
2. train. new attendant		1	10	cost/atte		34,000
				62,000		55,350
3. PPT training						0
4. Health dist. PHC refresher tr	30	2	3	15,000		225,000
5. H.A. PHC refresher training	38	1	3	5,000		122,500
SERVICES						
1. quality control						0
2. maint. cold chain	cost/hf:	4,000	# of hf:	64		12,000
3. transport vaccine YE-prov/3month	km/trip:	0	rate/km:	100		0
EXPIRY/SPOIL/PILFR/THEFT						
	stock value		# of			
1. Periph	0 of stock	500,000	64			350,000
2. Int. dep	0 of stock					
3. ProvDep	0 of stock				540,000	540,000
CONSTRUCTION						
					0	0
DEPRECIATION						
	number	value/fac	deprec/y			
1. prov. store&office	1	10,000,000	0		0	0

COST DESCRIPTION:

MONTHLY COST BY COST LEVEL IN FCFR

				PROV.	DEPOT	PERIPHERY
2. depot store	3	5,000,000	0		0	
3. building periphery	64	5,000,000	0			0
4. equipment periph.	49	250,000	0			0
5. equipment depot	0	500,000	0		0	
6. equipment prov.	1	500,000	0	0		
7. SD phcc moto	15	1,200,000	0	375,000		
8. HC motobikes	49	360,000	0	367,500		

SUPERVISION	#sup/mo	ka/sup	cfa/ka	nigh/mo	rate/nigh	
1. SD-HC						
50% of HC need	49	60	30	25	5,000	212,200
to spend a night out						
1 person	#nigh/sup	1				
2. D-SD						
quarterly basis	5	200	100	10	10,000	200,000
2 persons	#nigh/sup	1				
3. PROV-DIV.						
half year basis	1	1,000	100	5	10,000	160,000
2 persons	#nigh/tou	3				
4. HC-VHP.						
1sup/3 months	0	30	30			0

CAPITALIZATION COSTS

.67% of stock at all levels						
cash in hand and cash at bank w/h interest				0	0	0

PROVINCIAL FUND

				0		
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EQUIPMENT

1. SESA investe.				0	0	0
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ARTICLES

	cost/fac/mo			
1. consumer goods	5,000	5,000	15,000	200,000
2. printings(fores)	3,000	204,000		
3. stationary	1,500	1,500	4,500	95,000

total	3,348,817	879,832	4,228,650
Reserve margin	167,441		
Provincial Total	3,516,258		

Monthly drug purchase	5,737,219		
Markup by level	61%	15%	75%
total markup	152%	0%	8,608,650

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PROJET SESA HEALTH CENTER COST RECOVERY PROJECTIONS

1. INPUT DATA

1.1 FOR CURATIVE CARE

1.2 FOR PREVENTIVE CARE

Pop. covered by HC	6000 CPS cover*	0.500
HC util.rate*	0.25 CPS fee	200
Monthly HC/HC	125 CPN cover*	0.550
consult.fee	200 CPN fee	200
wound dressings	500 Birth rate	0.046
% wounds*	0.05 Mat.cover*	0.150
	Mat.fee	1000

*=assumptions

1.3 FOR DRUG CONSUMPTION AND PURCHASE

	Drug/Supply Item	drug consump. /100HC+	monthly drug consump.	AD LUCEM unit price	total price
1	Acide folique c6 5mg	50	62.50	1.75	108
2	Aiguille ID		0.00		0
3	Aiguille IM	15	18.75		0
4	Aiguille IV	3	3.75		0
5	Aiguille Suture		0.00		0
6	Alcool dénaturé 1l	1	1.25	952.00	1.190
7	Alcool iodé 1l	0	0.25	2353.00	588
8	Aminophylline amp 250mg	3	3.75	44.50	167
9	Aminophylline c6 100mg	17	21.25	3.50	53
10	Anti-Acide c6	160	200.00	6.00	1.200
11	Anti-Toux adulte 150ml	4	5.00	520.00	2.600
12	Anti-Toux enfant 150ml	5	6.25	395.00	2.469
13	Aspirine c6 500mg	1060	1325.00	2.00	2.650
14	Atropine amp .5mg	5	6.25	26.00	125
15	Bande comorie 5x3	7	6.75	64.00	580
16	Benzyl benzoate 1L	0	0.31	5071.00	1.685
17	Chloramine c6	10	12.50	6.50	81
18	Chloramphenicol c6 250mg	109	136.25	11.50	1.557
19	Chloramphenicol amp 1g	3	3.50	201.00	503
20	Chloroquine amp 300mg	8	10.00	52.00	520
21	Chloroquine c6 100 mg	986	1232.50	3.90	4.807
22	Chlorphéniramine c6 4mg	15	18.75	1.50	25
23	Collyre ophtalmique	3	3.75	290.00	1.088
24	Comresse 20x20	20	25.00	11.90	299
25	Contraceptif oral	3	3.75	200.00	750
26	Contraceptif injectable	3	3.75	400.00	1.500
27	Condom	15	18.75	100.00	1.875
28	Corticostéroïde c6 40mg	147	183.75	13.50	2.481
29	Diazepam amp 10mg	5	6.25	30.00	185
30	Diazepam 5mg	20	25.00	1.50	38
31	Diéthylcarbamazine c6	50	62.50	5.00	313
32	Eau distillée amp 5ml	35	43.75	27.00	1.181
33	Ergometrine amp .5mg	4	5.00	26.00	130
34	Fer c6	89	111.25	1.85	206
35	Fil catgut	3	3.75	400.00	1.500
36	Fil nylon/sort	3	3.75	200.00	750
37	Furoscnide c6 40mg	10	12.50	3.00	38
38	Furoscnide amp 20mg	1	1.25	27.50	34
39	Gant	3	3.50	255.00	893
40	Gouttes nasales	3	3.75	200.00	750
41	Lévanisole c6 40mg	15	18.75	6.60	121
42	Lévanisole c6 150mg	10	12.50	21.00	263
43	Lidocaine flacon 20ml	2	2.50	113.00	280
44	Mebendazole c6 100mg	45	56.25	12.50	709
45	Metronidazole c6 250mg	96	120.00	5.90	713
46	Multivitamine c6	50	62.50	1.70	106

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1.3 FOR DRUG CONSUMPTION AND PURCHASE

	Drug/Supply Item	drug consump. /100HCt	monthly drug consump.	AD LUCEM unit price	total price
47	Nystatine onguent	4	5.00	290.00	1.450
48	Ouate 800g	1	0.63	4328.00	2.704
49	Oxytocine amp 5ui	1	1.25	237.00	296
50	Papavérine cé	35	43.75		0
51	Paracétamol cé 500mg	84	105.00	4.90	515
52	Péni benzathine 2.4M	5	6.25	170.00	1.063
53	Péni procaine flacon 1M	52	65.00	115.50	7.508
54	péni G 1M	15	18.75	115.00	2.158
55	Perfusion glucosée 1l	3	3.75	705.00	2.644
56	Perfusion salée 1l	2	2.50	705.00	1.763
57	Perrnanganate cé 500mg	10	12.50	3.90	49
58	Phénobarbital cé 50mg	29	36.25	1.40	51
59	Prométhazine amp	3	3.75	31.00	116
60	Prométhazine cé 25mg	42	52.50	1.80	95
61	Quinine cé 250mg	150	187.50	17.10	3.206
62	Quinine amp 400mg	5	6.25	88.20	551
63	Sel de Réhydratation	20	25.00	60.70	1.518
64	Seringue 2ml	5	6.25		0
65	Seringue 5ml	7	8.75		0
66	Seringue 10ml	7	8.75		0
67	Sparadrap	1	1.25		0
68	Tétracycline cé 250mg	119	148.75	7.10	1.058
69	Thermometre		0.00		0
70	Violet de gentiane	2	2.50		0

Total monthly drug purchase 60.630

2. MONTHLY COST CALCULATION

COST DESCRIPTION:					COST

SALARY (CLERK)					
HC	25,000	number			
Allow/inc	0	1			25,000
PER DIEM		# PERS.	rate/day	day/trip	# h. fac
6 drug order/y		1	5,000	2	1
					5,000
MAINTENANCE					
		number	cost/vehicle		
Motobikes		1	5,000		5,000
building	5,000	1			5,000
TRANSPORT					
		#trip/y	rate/day	# h. fac	rate/ka
trip to depot		6	5,000	1	
incl.trans.cost consig					2,500
TRAINING					
		#attend	#/year	#days/trai	rate/day
N.A. PHC refresher training		2		3	5,000
					2,500
SERVICES					
saint.cold chain	monthly cost/hf:		6,000	# of h. fac	1
					5,000
EXPIRY/SPOIL/PILFR/THEFTH					
			stock value		#hf
HC stock	0 of stock		500,000		1
					2,500
SUPERVISION					
		#sup/ac	ka/sup	ofa/ka	nigh/no
rate/nigh					
HC-VHP.					
1sup/3 months		1	30	30	
					600
ARTICLES					
		cost/fac/no		# hf	
1.consumer goods		5,000		1	5,000
2.printings(forms)		10,000			10,000
3.stationary		1,500			1,500
DRUGS PURCHASE FROM DEPOT					137,440

total					214,290

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3. MONTHLY REVENUES

TYPE OF REVENUE	%	MONTHLY REVENUE	
Sale of drug	75%	225,249	apply HC markup to purchasing
fee curative care	8%	25,000	HC*fee
CPN	1%	2,400	birth rate*pop*fee*coverage
CPN	1%	2,540	birth rate*pop*fee*coverage
deliveries	14%	43,200	birth rate*pop*fee*coverage
dressings	1%	3,125	HC*%wound*fee
		100%	301,614

4. SUMMARY

FIXED AND VARIABLE COSTS

REVENUES	301,614	FIXED COST	74,350
COSTS	214,290	VARIABLE COST	139,940
DIFFERENCE	87,324	TOT. COSTS	214,290

5. SENSITIVITY ANALYSIS

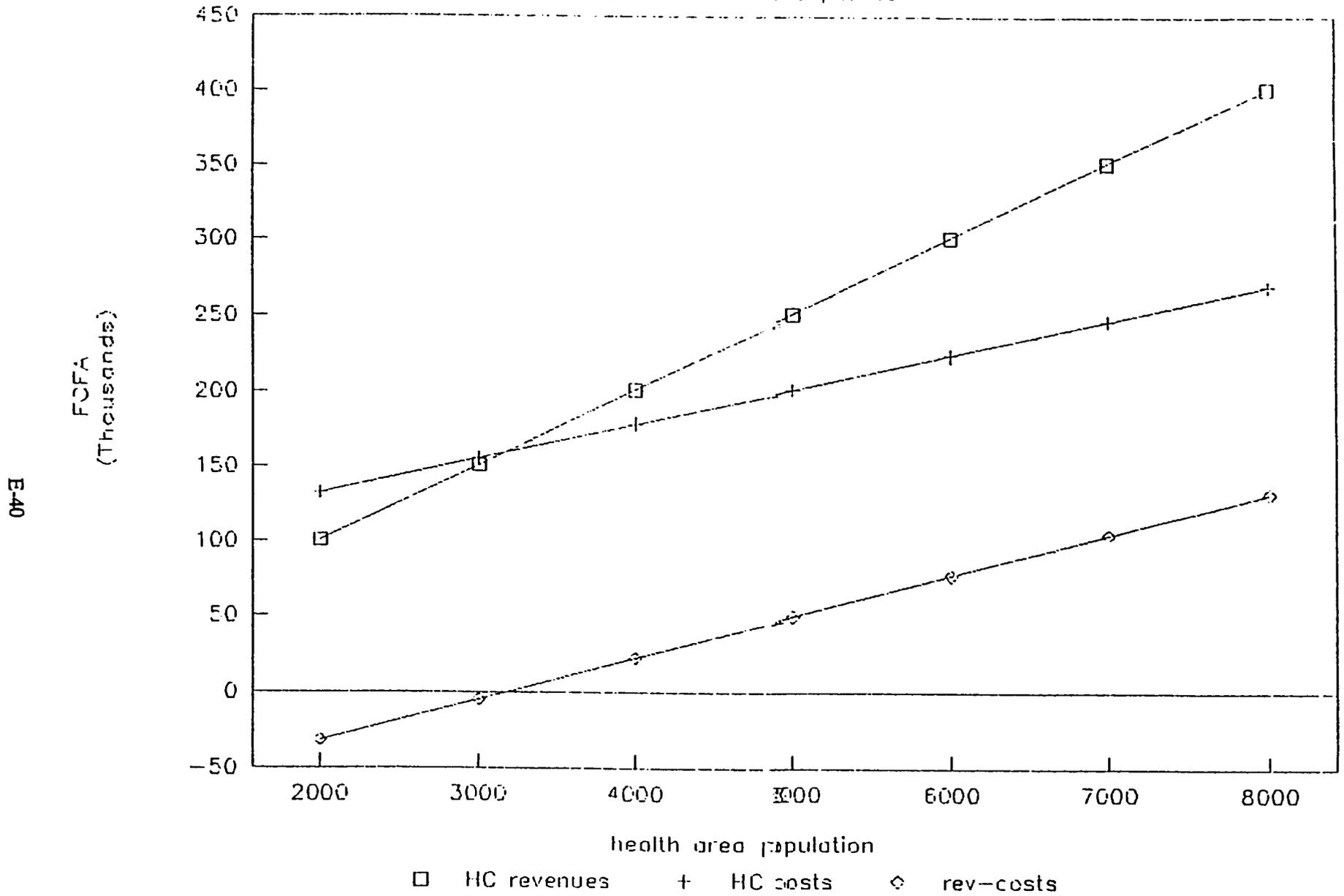
5.1. POPULATION

pop	rev	tot. cost	rev-cost	fix. cost	var. cost
2000	100538	132663	-32125	84350	48313
3000	150807	155570	-4753	84350	71220
4000	201076	178477	22599	84350	94127
5000	251435	201394	50051	84350	117034
6000	301614	224290	77324	84350	139940
7000	351883	247197	104686	84350	152847
8000	402152	270104	132048	84350	185754

SOURCE: PROJET SESA

FIG.1: HEALTH CENTRE COSTS AND REVENUES

vs size of health area population



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CAMEROON CONDOM SOCIAL MARKETING PROGRAM

EXPENSES

Line Item/Category	1990-91	1991-92	1992-93	1993-94	1994-95
Equipment					
-Computer and Printer	5,000	7,500	0	0	0
-Photocopier	3,500	4,000	0	0	0
-Office Furnishing	1,000	3,400	2,260	2,323	2,387
-Air Conditioner	3,000	6,000	0	0	0
-Vehicle	20,000	24,000	26,400	0	0
-Other	16,690				
Supplies					
-ORS(cost of commodity)	0	320,000	384,000	460,800	552,960
-ORS(cost of packaging)	0	24,000	28,800	34,560	41,472
-OC(cost of commodity)	0	0	0	0	0
-OC(cost of packaging)	0	5,000	6,000	7,200	8,660
-Condoms(commodity)	0	0	0	0	0
-Condoms(packaging)	55,000	42,000	60,000	72,000	86,600
-Korean Condoms(packaging)	0	8,333	8,333	8,333	0
-Korean Condoms(commodity)	0	0	0	0	0
Services					
-Subcontract Distributor	0	55000	60500	66550	72,205
-Research	4,000	13000	4400	4840	5,324
-Advertising	102,500	74500	73100	60335	49,799
Consultants					
	17,325	11000	12100	13310	14,641
Evaluation					
		500	8430	8430	8,430
Indirect Costs (overhead)					
	55,619	34211	35579	37002	38,481
Other Program Costs					
Personnel	62,990	124,986	137,799	146,554	161,578
Travel and Per Diem	65,435	55,954	74,053	61,275	74,053
Other Direct Costs	41,062	40,800	50,240	55,654	62,000
TOTAL ANNUAL COSTS					
	453,121	854,184	971,994	1,039,166	1,179,590

REVENUES

	1990-91	1991-92	1991-92	1991-92	1992-93	1992-93	1992-93	1993-94	1993-94	1994-94
SOURCE	Actual Revenue	Scenario #1	Scenario #2	Scenario #3	Scenario #1	Scenario #2	Scenario #3	Scenario #1	Scenario #2	Scenario #3
Contributions										
ET	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000
IDSTECH	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000
HELIC WELFARE	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000
EMLETT	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000
URIAH	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000
RO	52,000	0	0	0	0	0	0	0	0	0
SUBTOTAL	327,000	275,000	275,000	275,000	275,000	275,000	275,000	275,000	275,000	275,000
Sales										
Orders										
- Prudence	54,000	62,100	64,800	67,500	71,415	77,760	84,375	89,127	93,315	105,469
- Eorean	0	15,000	15,000	15,000	27,000	27,000	27,000	42,000	42,000	42,000
RS	0	198,000	396,000	594,000	827,700	475,000	742,500	261,555	570,240	928,125
OC	0	24,300	48,600	72,900	97,945	53,320	91,125	32,127	69,934	113,908
-Shirts	0	653	653	653	653	653	653	653	653	653
SUBTOTAL	54,000	300,053	525,053	750,053	954,713	638,933	945,653	415,772	776,139	1,199,155
TOTAL REVENUES	381,000	575,053	800,053	1,025,053	1,229,713	913,933	1,320,653	691,772	1,051,139	1,498,155
Contribution as % of Revenues	55%	49%	34%	37%	44%	30%	25%	40%	26%	19%

Et: Revenues based on following sales projections minus 10% of sales for loss and samples
 Orders generate \$1.00 each; ORS \$0.22; OC \$0.27
 Scen.1=15% annual sales growth
 Scen.2=30% annual sales growth
 Scen.3=35% annual sales growth

Orders	1990-91 Actual	ORS	OC
3,000,000	1990-91 Actual	0	0
3,450,000	1991-92 Scen.1	1,000,000	100,000
3,600,000	1991-92 Scen.2	2,000,000	200,000
3,750,000	1991-92 Scen.3	3,000,000	300,000
3,967,500	1992-93 Scen.1	1,150,000	115,000
4,320,000	1992-93 Scen.2	2,400,000	240,000
4,687,500	1992-93 Scen.3	3,750,000	375,000
4,552,625	1993-94 Scen.1	1,322,500	132,250
5,184,000	1993-94 Scen.2	2,800,000	280,000
5,559,375	1993-94 Scen.3	4,657,500	465,750
5,247,019	1994-95 Scen.1	1,520,875	152,088
6,220,800	1994-95 Scen.2	3,455,000	345,600
7,324,219	1994-95 Scen.3	5,559,375	555,938

1/4/95

CAMEROON CONDOM SOCIAL MARKETING PROGRAM

YEAR REVENUES COSTS BALANCE

Scenario #1

1990-91	381,000	453,121	(72,121)
1991-92	575,053	854,184	(279,131)
1992-93	629,053	971,994	(342,941)
1993-94	693,772	1,039,166	(345,394)
1994-95	772,537	1,179,590	(407,053)

Scenario #2

1990-91	381,000	453,121	(72,121)
1991-92	800,053	854,184	(54,131)
1992-93	913,933	971,994	(58,061)
1993-94	1,051,189	1,039,166	12,023
1994-95	1,767,674	1,179,590	588,084

Scenario #3

1990-91	381,000	453,121	(72,121)
1991-92	1,025,053	854,184	170,869
1992-93	1,220,653	971,994	248,659
1993-94	1,465,153	1,039,166	425,987
1994-95	2,064,414	1,179,590	884,824

*= Sales revenues sufficiently strong to remove all donor financial and commodity contributions

Technical Analysis

The population of Cameroon is growing at a rate of nearly 3% annually. The crude birth rate (CBR) is estimated at 42 births per 1,000 population and the crude death rate (CDR) is approximately 14 deaths per 1,000 population. The total fertility rate is about 6 births per woman. Infant and child mortality rates remain high, but are steadily declining as health services reach further into the countryside. With the current emphasis on reducing mortality rates without a concurrent effort to reduce fertility rates, it is likely that the CBR might increase in the next decade. The high rate of infertility now experienced by Cameroonian women has a direct impact on the CBR and efforts to reduce female infertility will have a negative impact on the CBR although it will have a positive physical and sociological impact for the affected women. Increasing education and job opportunities for Cameroonian women should help reduce the CBR.

Contraceptive prevalence is currently estimated at 2% of married women of reproductive age (MWRA) and contraceptives are available at less than 40 public and private sector health clinics and some pharmacies. There is little likelihood that fertility rates can change significantly unless there is substantial expansion of child spacing service outlets and increased information is made available to the population. There is anecdotal evidence of an unmet demand for family planning services, even for voluntary surgical contraception.

The aim of this project is to utilize public and private sector health delivery outlets, including religious, para-statal and for-profit health clinics, to make available child spacing services in Cameroon. In the public sector, the project is limited to four provinces and can expand only as fast as the MOPH's PHC program expands in those provinces. Part of USAID's strategy is to encourage donors working with the MOPH on PHC programs in other provinces to integrate child spacing/maternal health components of PHC. USAID would supply contraceptives for PHC programs in these provinces if the other donors are unable or unwilling to do so. By encouraging and assisting the religious, para-statal and for-profit health clinics to add child spacing/maternal services and supporting development of a condom social marketing program, the national network of family planning outlets will be increased.

The proposed USAID project will have limited demographic impact for Cameroon with an end of project target of raising contraceptive prevalence to 7% of MWRA. Rather, the project should be viewed as the first phase of a long-term effort to assist the GRC and people of Cameroon to achieve a better demographic balance by slowing the high rate of population growth. During this first phase, the aim is to set the stage for later expansion of family planning services by developing a strong cadre of trained health professionals, by involving private sector health clinics as well MOPH clinics, by strengthening the planning capability of the DFMH, and by widely expanding the availability of information about family planning to the men and women of Cameroon.

The GRC is gradually moving from a pronatalist policy to the current situation in which population issues are discussed openly and limited family planning services are provided. During the past two years the GRC has taken significant actions to institutionalize family planning services within the MOPH. The Directorate for Family and Mental Health (DFMH) was created in 1989 with responsibility for family planning services. With support of DFMH and donors, child spacing services are now offered at nearly 30 health facilities, some clinical training offered, seminars on reproductive health organized, media coverage of family planning events increased and availability of contraceptives is improving. In September 1990 a national population policy was drafted because of GRC concern with the growing economic crisis and the rapid rate of population growth. After rigorous debates in all ten provinces and at the national level, a draft population policy was reviewed by the Inter-Ministerial Technical Committee. The next step is for the National Population Commission to review and approve the policy and then transmit it to the national legislature or directly to the President for approval and promulgation. This is anticipated for mid-1991.

The policy calls for the development of integrated child spacing services and information in both the public and private sector health services in order to reduce the high rates of infant, child and maternal mortality, improve the health status of women and children and decrease the high rate of demographic growth.

The approach of the Cameroon National Family Health Project conforms to and supports both the MOPH/DFMH's strategy for ameliorating the health of women, infants and children and the MOPH/DPRM's revised primary health care (PHC) plan of action. The DFMH has developed a strategy which is based on the "risk approach" to identify profiles of women and children who are, respectively, at high risk of complications during pregnancy or at high risk of developing childhood diseases for which simple preventive measures have proven to be very cost-effective and efficient. This involves better pre-natal and post-partum care, care of newborns and heightened attention to child survival diseases. Amelioration of services can be achieved through better in-service training and supervision of service providers.

Many risk factors have been identified which apply to maternal and child health and include poverty, poor birth spacing, pregnancy late or early in the reproductive age cycle, maternal malnutrition, high parity, short stature and poor maternal weight gain. Medical providers have to consider these factors and decide at which level in the health system to operate. Worldwide experience has shown that active involvement in community health by medical providers, from TBAs at the village level to highly specialized physicians at the tertiary level, can have a dramatic effect on the management and reduction of risk factors and their unwanted outcomes. Thus the DFMH's guidelines for MCH/FP service providers follow a hierarchy, establish a referral system, identify minimum necessary resources, and outline specific responsibilities of service providers at all levels. Maternal health/child spacing interventions constitute an integral part of public health services, especially at the primary levels, where trained "polyvalent" health personnel are able to diagnose, treat or screen and refer patients to the next levels if needed. The active involvement of the nonmedical community, especially in regard to health education, to ensure the good health of mothers and their children is also promoted.

Furthermore, the integrated MCH/FP program respects the PHC plan of action currently being implemented in some regions under the auspices of the MOPH/DRPM. The PHC strategy will be expanded nation-wide in a phased manner since it involves the massive training (or re-training) of health providers and the establishment of community health committees at all levels. Although the brainchild of the DRPM, the PHC plan involves medical personnel at all levels and from all disciplines: hospital and pharmaceutical medicine, specialized and general physicians, nurses, midwives and assistants. Community involvement is paramount in making the system work. The plan entails the optimization of resources and skills at all levels and includes measures and incentives to ensure that the health facility hierarchy or referral system is respected.

While there may be an apparent lack of coordination and uncertainty concerning lines of authority or responsibility at the central level, in the provinces these phenomena are less evident. During site visits, the project paper team observed that lines of authority, from the health delegate down, seemed to be fully understood and respected by providers at all levels. In general, personnel assigned to the provinces work as a team, regardless of the central directorate under which they are counted.

While a restructuring of the MOPH is probably in order, the present situation does not seriously hamper effective service delivery at the provincial level. This indeed seems to be the consensus of other donors working in the health sector in Cameroon. And, given the evolving political scene in the country, a restructuring of the MOPH may be anticipated during the life of this project as changes may be necessary to accommodate opposition parties' demands for increased efficiency and "transparency" in the public sector.

Resolving the problem of the plethora of health personnel in the large urban centers to achieve a more rational and equitable distribution of personnel throughout the country will require a major effort and draconian measures which are unlikely to be popular or forthcoming in the near future. This need for a redistribution of government employees is blatantly apparent not only in the health sector but in other sectors as well. Some ministries, including the MOPH, have begun to conduct inventories of human resources and

early results indicate that the problem is so widespread and ingrained that only a massive revamping of the entire civil service system will begin to resolve the problem. This, of course, is beyond the scope of the Family Health Project but it is mentioned in passing since the team believes that the current situation could have a negative impact on the amelioration and expansion of services as envisioned under the PHC plan.

General Technical Issues

The project will support health interventions which entail the provision of a variety of medical products some of which, according to Cameroon's drug classification system, have restricted distribution. In this regard, Cameroon's drug classification system follows the French system as outlined in the Vidal (the equivalent of the American PDR). Tableau A drugs include, inter alia, oral contraceptives and antibiotics, involve limited distribution and require a medical prescription. Tableau B drugs are considered dangerous drugs and are prescribed using a special three page prescription form (one copy each for the prescribing physician, the pharmacist and the patient). Tableau C drugs are the least toxic, and while some may require a prescription, most are sold freely over the counter.

Under the project, products to be supplied include condoms, oral contraceptive pills (OCs), intrauterine devices (IUDs), Norplant, oral rehydration salts (ORS), and antibiotics such as penicillin and tetracycline to treat STDs. Condoms are not classified and can be sold freely anywhere. Likewise, neither IUDs nor ORS are classified but a de facto limited distribution of these products to only pharmacies and health facilities prevails. The project paper design team interviewed a limited number of pharmacists in Yaounde and learned that they will provide IUDs only to persons in possession of a prescription. All other medical products to be procured under the project are classified under Tableau A, distribution restricted to pharmacies and health facilities only.

Selected physicians will be trained in minilaparotomy under local anesthesia and diagnostic laparoscopes may be provided to three provincial public hospitals. Each of the preceding raises issues of safety and efficacy which must be kept in mind as the project is implemented.

Safety and Efficacy of Products and Services

1. Condoms

Condoms may be sold freely anywhere in Cameroon. The only major side effect is allergy to latex. This, however, occurs rarely and has no major health impact. Since condoms are designed for unique use only, failure rates due to incorrect or irregular use are relatively high. While theoretical failure rates are in the range of 2% per couple year, use failure rates vary from 12-50%. User effectiveness rate approaches that of the pill when foam or spermicides are used in conjunction with the condom. This indicates the need for IEC strategies to promulgate appropriate use as well as better training for method providers.

Furthermore, storage presents a particular problem for condoms. Latex deteriorates quite rapidly when exposed to high temperatures and ultra-violet light. Since condoms provided by USAID are packaged in transparent or translucent packs, community pharmacists must be instructed to keep them free from exposure to direct sunlight. Six hours of ultra-violet exposure will reduce condom burst strength by 83% which has particular implications for CSM distributors who must be taught the importance of keeping the condoms in their protective cartons which offer an added protection to the transparent packages.

Since there have been problems with defective condoms in Cameroon in the past, special care must be taken to ensure that quality control is strictly enforced. A condom quality control center has been established in Yaounde under the auspices of the WHO/GPA Program. All USAID-donated condom shipments must be routinely checked for defective products. An appropriate logistics system must be in place and stocks kept at a reasonable level, especially in regional depots and pharmacies where air-conditioned facilities are non-

existent. The monthly supply at each level of the health system must be assessed to determine accurate quantities to avoid stockouts as well as to maintain optimum product quality.

The association of condoms with the prevention of STDs, especially HIV/AIDS, and casual sex partners may have an impact on child spacing programs insofar as condoms are promoted as a regular method for couples. IEC campaigns should be designed to reduce the stigma attached to condoms and promote them as a legitimate prophylactic method.

2. Oral Contraceptives

The pill has one of the highest effectiveness rates of all nonsurgical contraceptive methods. In theory, effectiveness should be 100%, but in practical use the rate is 97%. Correct administration of the pill can be addressed through IEC campaigns and better training of health personnel and social marketing agents. The mini-pill, or progestin-only pill, is most often provided after a patient has experienced an estrogen-excess side effect from the combined pill and is the pill of choice for lactating women once breastfeeding has been established.

In recent years, the pill has often been the subject of unfounded rumors. In fact, the pill is much safer than its reputation would indicate and the death rate of pill users is one-third that of women who use no contraception. The most notable complications are extremely rare and include circulatory disorders such as stroke, myocardial infarction and thromboembolic phenomenon. Women most at risk of developing cardiovascular side effects related to pill use are those who have other characteristics that serve to increase their risk: they smoke, are over 35 years of age, or have other health problems such as hypertension, diabetes or a history of heart or vascular disease. Conversely, nonsmokers who are healthy and younger than 35 can use the pill safely with very little risk of developing serious complications. The African woman is less likely to have the characteristics that would serve to increase her risks: she is less likely to smoke, more likely to get physical exercise, is less likely to be obese, and is less likely to have a high-cholesterol diet.

The safety of oral contraceptives is such that many large countries, including Nigeria, Egypt, Brazil, India, Pakistan, Bangladesh, and Indonesia, now allow their sale without prescriptions. A 1989 operations research study in Senegal led to the recommendation that routine lab tests prior to prescribing the pill be eliminated. The study concluded that pregnancy-related health problems represented a far greater risk than those associated with utilization of the pill.

While oral contraceptives are not as susceptible as condoms to environmental degradation, protection from extremes of light and heat is prudent. This has important implications for social marketing and community based distribution programs (assuming that current efforts to change the classification of the pill from restricted to over-the-counter are successful so that these products can be distributed outside of pharmacies as is being done successfully in other countries around the world). Several pharmacists told the design team that they in fact sell orals over-the-counter without a prescription.

As in many African countries, horror stories about the pill are commonplace and often are promulgated by the Cameroonian press. For example, an article which appeared in the April 12, 1991 "Carrefour Sante" column of the Cameroon Tribune warned that women who used the pill were seriously "exposing" themselves to cervicitis. While an estrogen excess can possibly lead to cervical ectopia, this side effect is actually quite rare. The author of the column, a gynecologist, failed to mention any benefits of the pill. In many women, the pill minimizes menstrual cramps, decreases the number of days of bleeding and the amount of blood loss, produces regular menstrual periods and eliminates the pain of mittelschmerz in most instances. In addition, iron-deficiency anemia is decreased in pill users. Other women assert that premenstrual tension, anxiety or depression may be diminished while taking oral contraceptives. There is also extensive evidence that the pill provides a protective effect against pelvic inflammatory disease (PID). In fact, pill users are less likely to develop PID than users of all other contraceptive methods. The pill has been used in the treatment of

endometriosis and idiopathic thrombocytopenic purpura (ITP). There is a decreased incidence of functional ovarian cysts, rheumatoid arthritis, fibrocystic breast disease and fibroadenomas of the breasts in women who use the pill.

To conclude, journalists constitute another important target group for the project's child spacing IEC campaign and the press situation should be closely monitored to ensure that the public receives accurate information about contraceptives.

3. Progestin Injections or Injectables

Although injectables such as Depo-Provera will not be provided with USAID funds, other donors, such as UNFPA, will procure them for the national family health program. Injectables are classified under the pharmaceutical Tableau A, but again as in the case of the pill, they are freely sold over-the-counter in many pharmacies in Cameroon.

Used in over 80 countries (although not approved by the FDA in the U.S.), the injectable has gained popularity and is the contraceptive method of choice for many women in Africa. Reasons given by users for the great popularity are convenience, privacy afforded by the method and the traditional belief that injections have a greater effect than oral medications. Higher continuation rates are associated with less frequent visits to the provider.

Excessive endometrial bleeding and amenorrhea are the most frequent reasons for discontinuing the injectable. For cultural reasons, many African women are uncomfortable with a method that causes either breakthrough bleeding or amenorrhea (e.g., many African men refuse to have relations with menstruating women and amenorrhea leads to fears of pregnancy).

Nonetheless, in facilities where medical personnel provide thorough information to clients concerning possible side effects of the injectable, acceptance and continuation rates are high (such as at the NDjoungolo Protestant Hospital in Yaounde). Worldwide studies have shown that clients who had good foreknowledge of possible side effects of the injectable are more tolerant of those side effects and are less likely to abandon the method than clients who had no or scanty knowledge. This indicates, once again, the need for well-informed service providers and motivators with good communication skills.

4. Intrauterine Devices (IUDs)

The method effectiveness of IUDs is between 97% and 99% and user effectiveness is comparable at 90%-96%. One of the IUD's major advantages is that patients can make relatively few errors with it and its protective action is four years or more. The user-effectiveness depends on a number of administrative, patient and medical variables, including ease of insertion, clinician experience, the possibility that the patient will not detect whether the IUD has been expelled, and the user's access to medical services.

The IUD is generally considered an excellent option for women who have had their desired number of children and who, for a variety of reasons, reject sterilization or do not have access to such services. The IUD is also a good choice for women who have fear of the pill, have difficulty remembering to take them daily or obtaining additional supplies, or have experienced problems with the pill. Safe, effective, long-term use of an IUD can be recommended to women who have no history of PID, have only one sexual partner, and preferably, have access to medical care should one of the IUD danger signals arise (e.g., late or no menses; abdominal pain; increased temperature, fever, chills; noticeable or foul discharge; spotting, bleeding heavy menses, clots).

One of the principal concerns about the use of the IUD is that women who use it are more likely to develop PID than women who do not use it. Because of the high rate of PID and STDs in some areas of Cameroon,

this association may be a major issue in regard to recommending the IUD to certain women (see section below on infertility and STDs). Another major side effect of the IUD is uterine perforation upon insertion. This, however, is rare and can be minimized through proper training of service providers. While both of these side effects can have serious complications, including infertility and possibly death, death rates for women using the IUD are lower than for those using any other form of contraceptive and much lower than death rates for women using no contraceptives. In fact, a WHO study revealed that death rates from IUDs are lower than those of women using barrier methods which are usually considered to be harmless (the reason being that barrier methods are not as effective and expose the woman to a greater risk of pregnancy-related complications).

Less serious side effects involve changes in menstrual bleeding and increased menstrual cramping. This can lead to early removal and the need to change to another method. The principal cause of failure, however, is inapparent expulsion of the IUD, which often occurs during menses. As with other methods, this requires that health personnel receive accurate information and good training in counselling in the use of IUDs. In Cameroon, IUDs are considered to be medical devices which can be inserted only by qualified medical practitioners and they are currently not available in many pharmacies. In the past, only trained physicians performed insertions, but nurses and midwives are now being trained as well. Some nurses and midwives are reluctant to insert IUDs and contend, that until the MOPH authorizes them to perform insertions, they are unprotected by the law in the event of a clinical accident. Thus, the development, adoption and dissemination of standards and protocols which specify, inter alia, that nurses and midwives, with the proper training, may insert IUDs is a necessary condition for the promotion and expansion of IUD use.

USAID-supplied IUDs come wrapped in sterile packages which should only be opened by the service provider at time of insertion. If IUDs are to be provided through the social marketing program, distributors and sellers must be careful not to prevent damaging the packages. In Africa in recent years, discoloration (due to oxidation) of the copper on the TCU-380A IUD has been the cause of concern to service providers. This phenomenon was thoroughly studied by ST/POP which subsequently informed USAID missions that as long as the protective package was visibly undamaged and in good condition, the IUD could safely be used. The oxidation products of copper are similar to those formed in the uterine environment when the copper is naturally released and the oxidation process does not reduce the efficacy, lifetime or safety of the device. Nonetheless, distributors and sellers should be advised that, when in doubt, the IUD should be withheld from sale and brought to the attention of the social marketing managers.

5. Voluntary Surgical Contraception (VSC)

Although VSC is one of the most popular and, in the long-term, the most cost-effective methods of contraception worldwide, the rate of VSC in Africa is one of the lowest in the world. Recent experience in Kenya now suggests that the demand for VSC may be high among African women, especially those who have reached desired family size.

In Cameroon, during site visits to three provincial and confessional hospitals, the project paper design team noted that VSC (either laparoscopy with general anesthesia or mini-laparotomy with local anesthesia) was by far the preferred method of contraception at those institutions (easily over 50% of all FP clients). Demand for VSC was also evident during the first SEATS/DFMH mini-lap training held in Tiko in April 1991 at the Cameroon Development Corporation (CDC) main hospital. Prior to the training, CDC medical personnel conducted sensitization sessions in the neighborhoods surrounding the hospital and asked for 65 volunteers to undergo the mini-lap procedure. Seminar organizers were worried that there would be an insufficient number of volunteers for the practicum (each participating physician had to perform a minimum of 10 operations). To everyone's surprise, 175 women volunteered. Sixty-five women were eventually selected to undergo the procedure based on the following criteria: the patient and her spouse (if she was married) fully

understood the possibility of the irreversibility of the procedure and signed consent forms; the patient was over 30 years of age, had 5 living children and desired no additional children; the patient, after a thorough medical examination, was in good physical condition to undergo the procedure.

One of the major lessons learned during the Tiko training was the importance of counselling in conveying clear and complete information to potential VSC clients as it was evident that some of the volunteers had not fully understood the long-term consequences of the procedure. Individuals must fully understand that VSC procedures are to be considered irreversible. Couples wishing to maintain the option of having more children should be encouraged to use other approaches to birth control.

Of all VSC procedures for women, mini-laparotomy entails the least amount of risk and the least post-operative discomfort for the patient. Mini-lap can be done as an outpatient procedure with local anesthesia. Recovery time is short (1-5 days) and equipment costs are low. The procedure is relatively easy for general practitioners to perform and does not require a specialist (OB/GYN). The failure rate is 0.2%-0.6%. The procedure is more difficult with obese women or women not suited to local anesthesia (e.g., some women are very uncomfortable being conscious during the operation).

Mini-lap training will be carried out each year over life of project (3 seminars/practicums for up to 21 physicians per year). Each physician will be accompanied by a nurse colleague who will be trained to monitor patient blood pressure and other vital signs during the operation. The physician/nurse teams will receive intensive training in client counselling with 2 additional days of interpersonal skills training for the nurses. Each physician will receive a mini-lap kit and training in administering local anesthetic.

Equipment for local anesthesia is simpler and less expensive than that for general anesthesia. Nonetheless, equipment for resuscitation and artificial ventilation is just as essential as for general anesthesia and intravenous fluids should always be available. It is for that reason that participating physicians will be chosen from facilities where such equipment and supplies are readily available.

Given the Tiko experience and the large number of grand multiparas in Cameroon (TFR = 6+), it is estimated that greater access to mini-laparotomy services at the provincial and departmental hospitals will lead to a decrease in maternal mortality at these facilities.

6. Norplant

Norplant consists of a group of six silastic capsules which contain levonorgestrel, a synthetic progestin. From all indications, Norplant is one of the most effective reversible contraceptive methods developed to date and surpasses the pill and the IUD in this respect. Women whose weight exceeds 70 kilos have a greater probability of becoming pregnant than those weighing less than 70 kilos.

Norplant provides contraceptive protection within a few hours after insertion by a trained physician in the upper inside part of the arm of the client. Local anesthesia is used and the procedure takes 10-15 minutes. Its protective action lasts for five years and is particularly appropriate for women who desire a long-lasting contraceptive, a long spacing between children, a method which does not require frequent re-supplies, or for women who are considering VSC but are not yet ready for the finality of VSC. At the end of the five-year period (or earlier if the women so desires), Norplant should be removed by a trained physician, again using local anesthesia; in some cases, ultrasound or x-rays are used to localize the capsules if necessary.

Norplant should not be used by women who have a liver disease, jaundice or vaginal bleeding or women with a history of thrombophlebitis, pulmonary embolism, or cardiovascular problems.

A thorough medical examination is required and the patient must be in good physical condition prior to insertion of Norplant.

Under the project, a Norplant trial will be conducted by trained physicians from the CUSS. Approximately 500 women will participate in the trial. JHPIEGO will assist CUSS staff with the development, training in and implementation of protocols and monitoring procedures. Recently approved by the FDA for commercial use in the U.S., Norplant has undergone 20 years of intensive clinical trials involving over 55,000 women in 41 countries, including Ghana. In addition, over 280,000 women are currently using Norplant in 12 countries which have approved it for commercial sales. CUSS will benefit from the experiences gained to date and will contribute to the study of its acceptability for an African clientele. Similar trials are currently being contemplated with USAID financial support in Mali and Senegal and, if implemented, will permit a comparative analysis of results with those achieved in Cameroon.

No significant problems are anticipated with these trials. However, compared to other contraceptive methods, Norplant is a costly option (about \$25 for the capsules alone), requires local anesthesia, and trained medical personnel for insertion and removal. In the long run, the expansion of Norplant on a wide scale in low-income countries is questionable.

Infertility and Sexually Transmitted Diseases (STDs)

The inclusion of infertility and STD detection and treatment into the maternal health/child spacing program not only makes sense from a sociological point of view but from a technical one as well. Health education, prophylactic methods, early detection of deficiencies and infections, as well as adequate case management of STDs constitute a logical and integral part of maternal health/child spacing services.

As is discussed in the Social Soundness Analysis, in Cameroon, children represent the key to a happy life and failure to conceive is a personal disaster for couples. Therefore, the maternal health/child spacing services are designed not only to assist healthy couples to space births and determine the number of children they will have but also, to the extent possible, to prevent the spread of and treat STDs which are major causes of female infertility and pregnancy wastage. The development of strategies for detecting and treating infertility in males merits more attention since oligospermia (low sperm count) may be responsible for a significant percentage of infertile couples in Cameroon.

Cameroon is one of several African countries which constitute what demographers and medical researchers refer to as the Central African "Infertility Belt." The other countries included in the infertility zone include parts of Zaire and Chad, Sudan, the Central African Republic, the Congo, Gabon and Equatorial Guinea.

Overall infertility in Cameroon is estimated at approximately 15% (of women at 45 years of age) with a wide disparity among the different provinces. The Northern Provinces (Extreme North, the North and Adamaoua) and the East are characterized by infertility levels which surpass the national average. Some medical researchers speculate that over 30 percent of married women of reproductive age (MWRA) suffer from infertility in the East Province. (For the purpose of this paper, "married women" refers to women in union.)

It is further estimated that up to 85 percent of infertility cases in women are due to infection-related causes such as bilateral tubal occlusion, pelvic adhesions and acquired tubal abnormality. Furthermore, these infections are mainly due to a number of sexually transmitted microorganisms, such as gonorrhea and chlamydia, as well as to postabortal or postpartum sepsis. STDs are also associated with pregnancy wastage, ectopic pregnancies and low birth weight babies. While the level of HIV/AIDS cases are still relatively low (2%), it can be expected to rise given the high incidence of other STDs in the country.

Service providers at the integrated PHC health centers will have an important role to play in identification and treatment of STDs and other genital tract infections (GTI) since the health centers constitute the first level of formal public health care in Cameroon. Health workers must be able to provide accurate information to clients to enable them to avoid contracting or spreading STDs. Maternal health/child spacing programs deal with women and men in the reproductive age groups which are most affected by AIDS and other STDs.

Condoms and spermicides, which are major means of protection against STDs, are provided in such service programs.

HIV can be transmitted from mother to fetus during pregnancy or childbirth. Transmission of gonorrhea from mother to newborn occurs in at least 30 percent of the cases, resulting in gonococcal neonatal conjunctivitis and blindness if ocular prophylaxis in newborns is not implemented. The prevalence of a positive syphilis serology indicates a considerable risk for congenital syphilis. Women at high risk to contract STDs need to be counseled by trained health workers regarding possible risks to themselves and to their children.

Given the number of couples who face problems of infertility in Cameroon, health service providers can help if they know when to encourage patients to seek assistance and which diagnostic tests and prophylactic treatments are available. While semen analysis and hysterosalpingogram capabilities are available only at the central level (e.g., the CUSS and General Hospital in Yaounde), laparoscopy, principally for tubal ligation purposes, is performed at some of the provincial and missionary hospitals (e.g., Limbe, Bafoussam, Bamenda, Banson). Semen analysis, blood testing for RH factor, VDRL, the presence of antibodies and hormonal imbalances are also done in Yaounde, and the General Hospital may soon have an in vitro-fertilization capacity. In the future, if additional USAID funds are made available through, for example, non-project assistance, USAID and the MOPH may wish to consider the procurement of echography equipment for selected reference hospitals.

Performed under general anesthesia, laparoscopy, for diagnostic purposes, is a minor surgical procedure. The physician distends a woman's abdomen with carbon dioxide and inserts a laparoscope through a small incision below the navel to visualize her tubes, uterus and ovaries. A probe inserted through a second incision at the pubic hairline allows the doctor to gently manipulate these organs while looking at them through the laparoscope. This test reveals such problems as ovarian cysts, scarring around the tubes, damaged fimbriae and endometriosis and enables the physician to prescribe a treatment, from drug therapy and surgery to artificial insemination. Unfortunately, in the case of long, untreated infections, the damage is too severe and fertility cannot be restored. And, even in the cases where modern surgical methods and artificial insemination might be effective, these procedures are often beyond the means of those who could benefit from them.

The provision of diagnostic laparoscopes (where they are lacking) to OB/GYNs at the provincial hospitals in the project area will facilitate the detection and diagnosis of infertility in women in the regions and will preclude the need to travel to the capital city for this service. Laparoscopy training is an integral part of the specialized training in gynecology at the CUSS. Nonetheless, given that not all OB/GYNs currently practicing in the public sector received their medical training at CUSS, it is wise to include laparoscopy training for OB/GYNs in the reference hospitals under the project and to require that the provision of laparoscopes be contingent upon the existence of a functional operating bloc and aseptic conditions at the participating hospitals. There are qualified OB/GYNs, such as the director of the OB/GYN Department at the CUSS, who can carry out the necessary training in-country. The project, through a buy-in to JHPIEGO, will provide the necessary equipment, supplies and teaching materials to ensure optimal learning conditions.

Given that prevention is the best medicine, the project will emphasize early detection and treatment of STDs at the Health Center level. Health workers must be aware that while certain methods of contraception provide protection against STDs which are associated with pelvic inflammatory disease (PID) which in turn may lead to infertility, others may actually increase the risk of infection. For example, oral contraceptives can have a protective effect on the development of PID, but may render some women more susceptible to monilial infections. Barrier methods and spermicides reduce the transmission of many STDs. Spermicides and foaming tablets contain chemical ingredients which act against *N. gonorrhoea*, *T. pallidum*, *C. albicans*, *C. trachomatis*, and *T. vaginalis*.

However, the IUD can increase the risk of PID in women suffering from a STD. Therefore, the appropriateness of the IUD in areas where gonorrhea or chlamydia is endemic should be studied carefully and

the contraceptive benefits of the IUD thoughtfully weighed against the reproductive health problems that may arise. For example, it appears that for certain groups such as women who have multiple sexual partners, the IUD is not an appropriate method. In areas where STDs are endemic, IUD acceptors must be taught the IUD danger signals (late or no menses; abdominal pain; increased temperature, fever, chills; noticeable or foul discharge; spotting, bleeding, heavy menses, clots), most of which are early signs of PID. These clients should be counselled to return to the clinic immediately if these symptoms occur. In sum, good client selection, screening and counseling need to be emphasized during training and supervision of service providers who will be receiving and advising contraceptive users.

In regard to detection and treatment of STDs, the project will provide a start-up supply of Gram stain and Thayer Martin medium for Gram Tests (for detecting gonorrhea) to health centers and reference hospitals which have laboratory capabilities. JHPIEGO will provide technical assistance and local cost support for the training of lab technicians in STD detection and INTRAH will include the treatment of STDs in the in-service maternal health/child spacing curriculum to be developed under the project. A limited number of service delivery sites may be equipped with microscopes and priority given to reference hospitals and the larger health centers.

Drugs provided for the treatment of STDs and PID must be included on the essential drug list which is expected to be finalized and approved by the MOPH in the near future. For example, depending on the treatment protocols adopted by the MOPH, penicillin, tetracycline, and spectinomycin or cephalexin will be supplied for treating gonorrhea and tetracycline, penicillin G procaine, ampicillin or amoxicillin and probenecid for treating PIDs. For syphilis, TPHA Tests (or FTA-AB, MHA-TP or TRA-ABS) will be furnished for detection purposes, and penicillin benzathine, penicillin G procaine or tetracycline for curative purposes. Tetracycline is also used to treat chlamydia and metronidazole (flagyl) is used for trichomonas and Gardnerella vaginalis. Prior to the procurement of these medicines, treatment protocols, which will include alternative treatments in the case of patients who are allergic to certain drugs, must be established by the MOPH and health providers instructed in their use. Standing orders for health practitioners, particularly those working in isolated areas where access to microscopes or laboratory testing equipment is nonexistent, need to be developed. For example, where screening is unavailable, patients treated for suspected gonorrhea might also be treated simultaneously for chlamydia, since these infections often coexist.

AIDS control, as part of PHC, can take advantage of the expertise, resources, knowledge and infrastructure that maternal health/child spacing services will create. In turn, HIV/AIDS will have an inevitable impact on these services. In regard to contraceptive choices, clients may be faced with the choice between a contraceptive that has a higher efficiency for contraception and a contraceptive, such as the condom, which has a high efficiency against HIV transmission. It will be necessary to ensure that any procedure that may involve cutting the skin or injections is done in a way that does not contribute to the transmission of HIV. It will be necessary to make sure that needles, syringes and instruments are sterile. HIV-infected women will come to health centers and providers must be able to counsel these patients both about their own health and the health of their families. This is a very complex and difficult area which requires maximum sensitivity and understanding on the part of health personnel. Since the dominant mode of HIV transmission in Africa involves heterosexual transmission, pregnant women are among those who are likely to be HIV infected, with resulting transmission of the virus to their children, either before, during, or shortly after birth. While the efficiency of mother-to-child spread is presently unknown, a large number of worldwide studies have demonstrated a 20-50% risk of perinatal transmission. In areas of Africa where 10 percent or more of pregnant women are HIV seropositive, as many as 5 percent of all newborns may be HIV infected from birth. Pediatric AIDS, particularly difficult to recognize where malnutrition and respiratory and gastrointestinal infections are common, is an increasing problem in Africa and health providers need guidance in dealing with this tragedy. The National AIDS Committee needs to do more in the area of developing HIV/AIDS protocols and treatments. In fact, one of the shortcomings of the project is the absence of an HIV/AIDS component which should be rectified if additional funds become available in the future.

If the cost of managing STDs is assessed in terms of hospitalization, infertility, pelvic inflammatory disease, ectopic pregnancy, and low birth weight infants, STD screening would be very cost effective. There is a clear link between acquired infertility in women and STD-related upper genital tract infections. Infertility in the couple has important psychological and social repercussions. Moreover, in a country such as Cameroon, infertility is a community health problem which has severe social implications and can even delay socio-economic development. The success of infertility treatment is often very costly and unsatisfactory; therefore, prevention should be emphasized. A major component of prevention of infertility is the implementation of an effective STD control program. For the sake of comparison, it is estimated that the so-called "hard-core" infertility is thought to affect 5% of all couples on average and could be due to a woman having had a hysterectomy or irreversible sterilization as well as to other causes. Thus, the effective prevention or early detection and treatment of STDs could conceivably contribute significantly to a reduction in the number of infertile women in Cameroon.

It is evident that maternal health/child spacing services have a major role to play in STD control and infertility treatment, particularly in women. Alternate strategies may have to be developed to attract men to services sites or to otherwise educate them since, aside from their role in transmitting STDs to women, oligospermia may be responsible for up to 40 percent of cases of infertility in Cameroon, as has been suggested by one expert. Furthermore, on a world-wide scale, oligospermia is recognized to be responsible for the bulk of unnecessary or potentially curable cases of infertility in couples. Thus, the possibility of male infertility must also be seriously considered by health personnel when confronted with infertile couples.

Background on Family Planning in Cameroon

Family planning in Cameroon has come a long way, albeit slowly, since a 1920 French law prohibited the import, sale or promotion of contraceptives. That ban was re-confirmed in 1969. The ban remained in effect until 1980 when another law permitted the possibility of sales of contraceptives by private pharmacies. A National Population Commission was created in 1985. Finally in 1989, law No. 011/889 created the Directorate of Family and Mental Health within the Ministry of Public Health. Cameroon has a population policy statement in draft, expected for promulgation in mid-1991.

In the public sector, child spacing services were first offered in 1975 at the Central Hospital in Yaounde in response to the extremely high rates of maternal mortality in its maternity clinic. A High Risk Pregnancy Clinic was established there. In ten years, the MMR was cut in half. By 1982 the GRC recognized and officially accepted family planning as a strategy to reduce maternal mortality. Within the public sector, child spacing services are now offered at High Risk Pregnancy Clinics at provincial maternity wards and at MCH Centers (protection maternelle et infantile or PMI) in five provinces: Central, Littoral, Northwest, Southwest and West. In 1990, through the DFMH, 25 health facilities in five provinces launched child spacing service delivery activities. The DFMH, with donor support, coordinates the implementation plans for contraceptives logistics and distribution of supplies and training and supervision of health personnel. The DFMH has also standardized training materials and management information systems and obtained the agreement of donor agencies to contribute their contraceptive stocks to the government operated contraceptives supply and logistics system.

Private sector health facilities currently offer a reliable addition to the limited public sector child spacing and maternal health services. Most of the private sector health services are provided by religious organizations; other private sector health providers include the health clinics of para-statal organizations and large private companies and for-profit health clinics.

Mission hospitals have been pioneers in providing child spacing and maternal health services in Cameroon. By offering high quality, reliable services, these hospitals have gained the confidence of family planning acceptors. It is worth noting that women are willing to pay moderate fees for services at these facilities, thus sustaining the MCH programs at these hospitals. In 1981, Djoungolo Protestant Hospital in Yaounde became

the first mission hospital to offer family planning services. It now provides outreach services to mission hospitals in Mbalmayo, Bafia and Mettet. Mbo Protestant Hospital in West Province also has an active family planning program with outreach into the community. The Cameroon Baptist Convention offers family planning services at Bansa Baptist Hospital and training of health personnel in child spacing/maternal health through its two year nursing program. A number of Catholic hospitals provide counselling on natural family planning methods to interested women.

Fifteen para-statal companies provide curative health services through company dispensaries. According to GRC law, companies employing a minimum of fifty employees must have a small dispensary with a clinical officer who should receive supervision from a part-time contract physician. Companies with at least 150 employees are required to have a dispensary with full-time staff, often obtained through a contract with a local physician. Although many of the para-statal companies have provided family planning IEC materials prepared under a UNFPA project, none of the companies currently offers family planning services. Under the private sector component of this project, training and the provision of child spacing services will be introduced into these para-statal companies.

The Cameroon Development Corporation, the second largest employer in Cameroon and a para-statal, employs about 16,000 workers (with 64,000 dependents), mainly low-paid agricultural workers on large plantations. The CDC operates three hospitals, 19 dispensaries and 67 health posts. Recently three CDC gynecologists and three nurse-midwives were trained in family planning services, including voluntary surgical contraception, and in family planning counseling and record keeping. The CDC health facilities do not yet offer family planning services but are included as one of the parastatals to be beneficiary of this project.

The Organization of Cameroonian Trade Unions was created in 1988 and regroups employees from 26 large companies. Each company offers curative health care services. Again, while each of the companies has developed a team to provide family planning IEC materials to employees and has a nurse trained in family planning service provision the OCTU does not currently offer family planning services. Employees are referred to Djoungolo Protestant Hospital's family planning clinic. This is another targeted organization under the project.

There are a large number of for-profit private sector health clinics, many of which are small clinics operated by individual physicians. All are potential providers of family planning information and services, but there is no good estimate of the number of such clinics which now offer family planning services.

Over the past 15 years, USAID has pursued a cautious approach to population assistance in view of GRC sensitivities. Without a bilateral population project, USAID has made extensive use of the S&T/POP centrally funded cooperating agencies to respond to specific requests from both public and private sector institutions. Assistance in early years included support of awareness-raising among policy makers and policy influencers; contraceptive supplies and equipment; training in IEC and family planning methods; biomedical and social science research; transfer of computer hardware and software; and technical assistance.

In 1988, AID developed the Family Health Initiatives-II Project, consolidating a number of centrally funded population activities. Under this umbrella project, USAID supported sub-projects in IEC, management training, reproductive health training and curriculum development, and family planning services delivery. S&T/POP funds continue to support operations research studies through the Population Council and family planning information and services at selected Protestant hospitals through the SEATS project.

Since 1987 the GRC has sought assistance from bilateral and multilateral donor agencies to implement the reorientation of primary health care (PHC). While most donors have agreed to assist the GRC to implement the revised PHC strategy in specific provinces, few donors have offered to support the child spacing and maternal health interventions. The major donor agencies providing population assistance and their current activities are as follows:

CAMEROON NATIONAL ASSOCIATION FOR FAMILY WELFARE (CAMNAFAW). CAMNAFAW was recognized by the GRC in 1989 as a not-for-profit organization and receives financial support from the International Planned Parenthood Federation of which it is a member. It has concentrated on educating the population about family planning and responsible parenthood through seminars for specific community groups. CAMNAFAW does not operate any family planning clinics at present but plans to open one in 1992. It works closely with DFMH to train midwives in child spacing and to provide contraceptives, supplied by IPPF, to public and private clinics. CAMNAFAW expects to open in mid-1992 a Youth Center to support family life education.

GERMAN GOVERNMENT COOPERATION (GTZ). GTZ supports the PHC program in parts of Northwest, Southwest and Littoral Provinces. GTZ expects to integrate child spacing activities into the PHC program once a national population policy is approved. GTZ also provides support for improving refrigeration capabilities for the Expanded Program of Immunization (EPI).

JAPANESE GOVERNMENT COOPERATION. The Japanese Government has provided a grant of \$1,000,000 for population activities within the framework of the World Bank SDA project. The grant will cover training of personnel, strengthening MCH services, renovation of two MCH centers and provision of vehicles and equipment. The grant has not been signed yet with the GRC.

SAVE THE CHILDREN (SCF). SCF operates a rural health program in two departments of Far North Province under a research grant from the Population Council in which village health promoters and village opinion leaders receive information about child spacing practices. Traditional birth attendants are provided condoms and spermicides for distribution.

UNITED NATIONS POPULATION FUND (UNFPA). UNFPA supports the delivery of child spacing services in eight MCH clinics in Yaounde and Douala. Working with the Ministry of Social and Women's Affairs, UNFPA supports IEC and family life education projects. UNFPA has taken the lead in assisting the GRC to develop a national population policy and improve its demographic planning capability. During its 1992-1996 budget cycle, UNFPA will expand its support for child spacing activities in major urban areas

WORLD HEALTH ORGANIZATION (WHO). WHO funds support research in reproductive health at CUSS. In addition, WHO acts as the implementing agency for UNFPA-funded child spacing clinics.

Social Soundness Analysis

I. Introduction

The purpose of this analysis is to examine the socio-cultural context of this project, support the technical analysis and to confirm the socio-cultural feasibility of it.

II. Population

In February, 1991, the Government of Cameroon presented the results of the 1987 census of the population. Compared to the 1978 census, it revealed that fertility is high and remaining stable, mortality is slowly declining, especially for infants and children, the average age of the population is getting younger, and there are important migratory movements, including rural exodus and rapid urbanization. Unless otherwise cited, data on population come from the results of the 1987 census as released by the Government of Cameroon.

After decades of being a pro-natalist country, Cameroon has a national population policy now in draft. It advances the strategy of "responsible parenthood", which means that parents should plan and be responsible for their families in function of their resources to provide for them and their hopes and beliefs.

A. Characteristics

Cameroon is situated in Central Africa and is bordered by the Atlantic Ocean on the West, by Nigeria on the West and Northwest, by Chad and the Central African Republic on the North and Northeast, and by Equatorial Guinea, Gabon and Congo on the South. The Cameroonian territory covers 475,000 square kilometers, ranging from a sahelian ecosystem in the far north to central and southern plateaus to western highlands and coastal plains.

The total population in 1987 was 10.5 million, according to the 1987 census. At a rate of increase of 2.9% annually, the 1991 population should be 11.9 million inhabitants. If this rate of growth continues, in 2000 Cameroon will have over 15 million people. The 2.9% annual growth rate puts Cameroon in the category of countries which are characterized as having rapid rates of population growth. It also means an annual increase of some 330,000 persons. (Analyse de la Situation de la Femme et des Enfants en Republique du Cameroon, June 1991: UNICEF). This family planning project, but through a strategy of child spacing/maternal health and responsible parenthood, will attempt to increase the numbers of family planning acceptors and promote improved maternal and child health through child spacing.

B. Distribution

The population of Cameroon is very unevenly distributed over the territory. Although the average density is 22 persons per square kilometer, variations among provinces show as few as 4.7 in the East province to a many as 95.8 in the west province. The table below shows the population broken down by province and density:

POPULATION AND DENSITY BY PROVINCE (1987)

<u>Provinces</u>	<u>Population</u>	<u>Density</u> (persons/Km ²)
Adamaoua	491,000	7.9
Center	1,656,000	24.0
East	517,000	4.7
Extreme North	1,881,000	54.9
Littoral	1,352,000	66.9
North	833,000	12.3
Northwest	1,238,000	71.5
West	1,331,000	95.8
South	337,000	8.0
Southwest	841,000	33.8

(Source: 1987 Census)

71% of the total population lives in five densely populated provinces: Far North, West, Northwest, Central and Littoral, which together represent one-third of the total land area.

Cameroon is rapidly becoming urbanized. Currently, 37.3% of the population lives in cities, and 62.7% lives in rural areas. 49% of the urban population lives in one of the six cities with over 100,000 inhabitants. In the early 1960's, only 20% of the population lived in urban areas. If this 5.6% per annum rate of urbanization continues to the year 2000, over one-half of the population will be living in cities.

C. Migration

Cameroon has a long history of migrations: nomads in search of pasture, displacement of peoples by religious and ethnic wars, movement of traders for economic reasons, labor migrations to agro-industrial zones and most recently, rural exodus. 32.5% of the population can be classified as migrants. The three principal zones from which migrations stem are the most populated areas: Far North, West and Northwest, and the Center. The areas attracting these migrants are the two principal cities in Cameroon (Yaounde and Douala), underpopulated rural zones (such as Adamaoua and the North) and the agro-industrial zones of the Southwest and Littoral, including mid-sized cities and provincial capitals. (Program Review and Strategy Development Mission Report, March, 1991: UNFPA) Although the causes for migration are complex, Trouve and Bessat, 1980, as cited by UNICEF, have determined that the principal problem is the increasing difference between the socio-economic realities of the rural areas and the new aspirations of youth.

D. Structure by Age and Sex

Cameroon has a young population and it continues to get younger. In 1987 56% of the population was under 20 years of age and 47% was under 15. Given the fact that the level of fertility remained relatively stable from the 1960's to the present, the rejuvenation of the population is explained entirely by the reduced infant and child mortality rates. A younger population means that this project will have to target IEC messages and child spacing to youth as well as couples in long-term unions.

The population structure by sex reveals that there are slightly more females than males nationwide, 51% compared to 49% for men. This breakdown has remained relatively stable overall. In urban areas, however, women make up 49% of the population which reflects male migration to the cities.

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In rural areas, women make up 52% of the population (108 women for every 100 men), which reflects the male emigration.

III. Social Organization

The social organization of Cameroon is characterized by its diversity, a legacy of the history of its peoples and the geographic and climatic conditions which determine the way of life of its peoples. For example, societies organize themselves in certain ways to make good use of the economic resources at their disposal: in some areas rainfed agriculture is the norm, in others its livestock raising, hunting and gathering, fishing, etc. Cameroon has been described as Africa in microcosm, and indeed, ethnically, culturally, economically and geographically its diversity is astounding and certainly makes it difficult to generalize.

A. Ethnic groups and languages

There are approximately 200 distinct ethnic groups in Cameroon, each with its own language. Following is a province by province breakdown of the predominant groups. With the exception of the Pygmies, each is represented in each of the large cities in Cameroon. Only the Pygmies tend to remain in traditional locales:

- Center and South provinces: Boulou, Ewondo, Eton, Bafia, Sanaga, Fang and Batanga.
- Littoral and Southwest provinces: Bakossi, Mbo, Bakundu, Douala, Bassa, Ekai and Mbembe.
- East province: Baya, Kaka, Maka and Pygmy
- West and Northwest provinces: Bamileke, Bamoun, Bamenda, Widekum and Efik.
- Adamaoua and North provinces: Adamaoua, Arabe, Benoue, Peul, and Hausa.
- Extreme North province: Chari, Mandara, Toupouri, Logone, Wandala and Guiziga. (UNICEF)

Although each group speaks its own language, making over 100 national languages, there are at least two lingua franca in the country: pidgin and peul. English and French are the two official languages. Cameroon is a bilingual country.

B. Social structures

The societies in the forest regions are without strongly established chiefs and their social organization is based on clan and lineage allegiances. The Pygmies live in small groups, without a hierarchy and remain essentially isolated.

On the plateaux of the West and Northwest, the populations are grouped by autonomous chieftains and are competitive. These chieftainships centralized their power and remain powerful even today.

In the North, two different situations exist. The Islamic people are organized by chieftainships which were established after the jihad. These chieftainships governed the whole region including where the non-Islamicized people continued to live. These non-Islamicized people were dominated by the Islamic administration but managed to keep their own lineage-based social organization in areas where they could live in the hills (and away from the Muslim administration). Their social organization was not strongly centralized nor did it have a pronounced political hierarchy.

In spite of all these differences, the family, more or less extended, or a part of the lineage, constitutes

the basic unit in Cameroonian social organization. The role of the family is primordial, whether it is for its role in procreation, socialization, education or economic support. It is also the family which is the first unit to experience the influence of changes in the economy or society. Focus group discussions conducted in 1986 and 1987 show that families are feeling the economic crisis in Cameroon as reflected in less disposable income, more cases of wife-beating, marriage breakups, drunkenness, jealousies, etc.

C. Religions

Three main religious groups exist in Cameroon, all of which influence attitudes towards child spacing, and all of which still have strong undercurrents of traditional religion:

- Animists, which are in almost all the provinces and make up 39% of the population. Animist populations have been gradually reduced with Christian evangelism and Muslim conversions over the years. Since animism is not one religion or set of religions, it is difficult to tell in what way animists might be influenced.
- Christians, who are concentrated in the Center, East, Littoral, Northwest, West, South and Southwest provinces comprise about 40% of the population. The majority of the Christians are Catholics. Protestants tend to support family planning and their health clinics and hospitals even provide services. They support a "responsible parenthood" approach. The Catholics, on the other hand, receive guidance on this question from the central authority in Rome. Worldwide, the Pope has come out against any artificial methods for child spacing, which is what the Catholic churches in Cameroon are obliged to teach.
- Muslims, who are found especially in the Adamaoua, North and Extreme North provinces, but also in the Center and West provinces, make up 21% of the population. Muslims are allowed to be polygamous and view men who have lots of children more favorably. For devout Muslims, children are gifts from God and procreation should not be tampered with.

D. Education

In spite of enormous efforts by successive governments to promote education and training of the population, the educational situation in Cameroon is still cause for concern (UNFPA). According to the 1987 census, 40% of the population over 11 years of age does not know how to read or write. For women, it is 50%; for men it is 30%. For all people over 3 years old, 44.9% of men and only 37.3% of women have been to primary school, 14.6% of men and 8.9% of women have been to secondary school. For university level education, the figures are 1.3% for men and 0.3% for women.

Internal and external efficiency of the school system are poor: One-third of the children in primary school abandon it before completion. In spite of the fact that the vast majority of primary school leavers do not continue their education, the system still concentrates on preparing students for secondary school, which prepares students for higher education.

Girls suffer more as school dropouts at all levels than boys and the reasons for this vary:

- pregnancies occurring during the school year;
- parental preference for keeping a boy in school if they have to make a choice;
- familial disruptions (marriage, divorce, deaths);

- diverse reasons such as age, discipline, health;
- fear that the girl will be better educated than her eventual husband;
- the idea that the girl is made for housework;
- the uneasiness of parents for their girls' security as the girls approach puberty;
- domestic responsibilities and tasks which sometimes overwhelm girls. (UNICEF)

Studies the world over have shown a direct correlation between the level of girls' education (beyond the first few years of primary school) and fertility rates, rates of infant mortality, health and nutritional status of their children and family planning acceptance. Keeping girls in school longer means better maternal and child health.

Family life and sex education in the public schools is almost non-existent even though a 1988 survey of secondary students in Yaounde found that 70% had sexual relations (81% boys and 56% girls). Biology and anatomy classes teach the students about reproduction and reproductive organs, how they work and how to use them, but the schools do not teach anything about family planning.

IV. Political and Administrative Organization

Cameroon has been independent since 1960, united (the French and English speaking territories) since 1972 and has had only two presidents. In 1985, the Rassemblement Democratique du Peuple Camerounais (RDPC) replaced the Union Nationale Camerounaise (UNC) as the only party.

Cameroon is divided administratively into ten provinces, which are divided further into 49 departments and 182 arrondissements. The administrative analysis of this project provides a description of the political and administrative divisions.

The legal system is complex because it allows the traditional legal system to coexist with the modern.

The traditional administrative structures are generally found at the village level, where Cameroon continues to follow the system of "indirect rule" begun by the English colonists. "Traditional" chiefs are appointed by the Government, even in areas which are traditionally without chiefs. Village or community development committees, from which the health committees are formed under the reorientation of PHC, are formed by the Community Development services and often bridge the gaps between the state and the traditional structures in a village. In this project, these committees will play an important role in providing information on child spacing to the community and in managing the health centers and the pharmacies.

V. Familial and Cultural Environment

A. Family concepts and Lineages

In Cameroon as all over Africa, the family is seen as much more than just mother, father and children. According to some Cameroonians, "the family extends to all persons descending from a common ancestor, as far back as six generations." Others view the family as all the relatives of both inlaws, and others have an even larger idea of the traditional family: "It is made up of all those who often come together, give each other advice, unite against wrongdoing, and celebrate good conduct and happy

occasions" (Recherche sur la Famille Camerounaise, March 1988, MINASCOF). In urban areas, this concept is breaking down, in part because of western influence, but mostly because of reduced economic and social possibilities such as unemployment, smaller living quarters, no possibility of farming, increased reliance on a money economy, etc.

Marriages have traditionally been arranged in social groups of the same ethnic affiliation. Generally arranged by parents, and always preceded by exchanges between the two families (which have gradually become monetarized), marriages have generally united a young girl with a mature man. According to the 1987 census, of all Cameroonians over 15 years of age, 55% of Men and 63% of women are married.

71% of all women are married before the age of twenty, while between 12% and 21% of men marry before the age of 25. About 10% of all women have their first child outside of marriage. In many societies, girls are expected to show that they are fertile by having at least one child before marriage.

Polygamy has always been important in Cameroon: 22% of men are polygamous and 38% of married women have a polygamous husband. In addition, many of the youngest women are married to polygamous husbands who have already three or four wives. (UNICEF)

The National Fertility Study conducted in 1978 found that marriages in Cameroon are very unstable. The most stable marriages are found in the West and Northwest provinces. In the three northern provinces, the East, South and Center, marriage breakups are most common. Remarriage by the women is also very high, which shows that women frequently change partners and don't remain long in a state of divorce, separation or widowhood. More women than men are divorced or widowed, because of the high rates of polygamy.

According to a MINASCOF study on divorce in the then-Centre-Sud province, 74% of divorces are requested by women who give as principal reasons the poor treatment by their husbands, infidelity, and abandonment.

B. Cultural Values and Attitudes Towards Fertility

Fertility is highly valued in Cameroonian society. Proof of a woman's fertility is traditionally required in some societies before she can be married. Many other societies have behavioral taboos or beliefs around fertility. A woman without a child is considered a sorceress or a host for bad spirits. Among the Beti in South Cameroon, the number of deliveries a woman has is criteria for her to enter certain women's groups. Sterile women in Northern Cameroon consider themselves handicapped, and as a result, information on infertility is not usually volunteered.

If a woman doesn't have a child right away after a marriage, psychological problems could result. She fears separation, repudiation or the beginning of a polygamous relationship. Often the in-laws traumatize a woman more than the husband. Whether a woman has a child or not plays a role in the stability of the marriage. If she doesn't have one, the woman may want to change husbands to try again. If this persists, changing husbands often can lead to prostitution.

Cameroon is part of a belt of infertility which extends across Central Africa, caused by venereal diseases which were introduced at colonization. The rapid evolution of these diseases was favored by social organizations of certain Central African populations. Untreated, these venereal diseases can result in sterility.

Where sterility has been found to exist, rates of STDs are high, although the inverse might not be true (Evina Akam, Sept, 1989). Self-induced or amateur abortions are also said to be a major cause of

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infertility. Early age of girls at marriage could cause infertility because their bodies are often not well enough developed to bring a pregnancy to term and damage could be done to the uterus.

According to doctoral research by Evina Akim (Evina Akim, Sept. 1989) the East and the Extreme North provinces have the highest incidences of STD and of infertility, at 29% and 45.6%, respectively. The national average is 26%, which is extremely high compared to other African countries: Rwanda 5.9%, Kenya 10.4%, Ghana 10.7%, and Lesotho 13.1%.

Surveys have shown that there is a remarkable link between ethnic group and sterility in Cameroon. Rates of sterility vary sharply when one crosses ethnic lines, but not national or geographic barriers. Therefore the explanation of sterility is tightly connected to cultural practices. (Akim, Sept. 1989). Cultural habits and practices around marriage such as the age of the woman at her first marriage, the number of marriages she has, religion and whether or not any of the marriages are polygamous are important factors in infertility and sterility.

Attitudes towards family planning and child spacing have to be understood within the context of fertility and its importance. 38% of Cameroonian women are at risk of infertility (Evina Akim, Sept. 1989), and gynecologists the design team spoke with reported that infertility brings one-third of their caseload. A woman must be helped to have a child before she will be interested in spacing children.

Cameroonians have traditionally practiced child spacing. At the birth of a child, in some societies, the mother would return to her family for two, three or four years, resulting in forced abstinence. Cameroonians today remember their parents practicing this traditional method, although now fewer and fewer parents practice it. Other traditional methods that women use are the wearing of amulets or gris-gris, drinking potions and rubbing or inserting special mixtures of leaves or roots on their bodies. Women are aware of the traditional methods of contraception, but mostly ignorant of the modern methods.

C. Women's Role

Women in Cameroon, like in the rest of Sub-Saharan Africa, are the main producers in agriculture, play a major role in the education of children and are the heads of one in five households (UNFPA).

The most important role for any woman in traditional Cameroonian society is procreation. This is why there is such concern about fertility in Cameroon. There is a felt need to give birth to a great number of children, because the expectation is that a certain number of them will not survive beyond the first few years. A recent IFORD study found that the real number of desired children (that is, if they all survive to adulthood) among Cameroonian women is 3.

Another important role for women is the education of their children. Not only are women responsible for the socialization of their children in the family and traditional society (although in rural areas the extended family also takes part in this), more and more women in Cameroon are also responsible for the formal education of their children: paying school fees, buying books, uniforms, etc. In recent years men have declined responsibility for this even though earlier the men were responsible for financing their children's formal education.

Women's role in food production and processing is vital in rural areas. Women are largely responsible for family garden and for staple food production. They perform the tedious and difficult work of hoeing, sowing, weeding, harvesting and storing. They usually also help weed in their husband's cash crop fields. In addition, women are responsible for water and fuelwood gathering.

Women also prepare all the food, usually have some small commerce when they can and take care of all domestic household chores.

In spite of their important roles in societies and their demographic importance, women are still relegated to a low status, treated as objects or as beasts of burden for men. Women's low status is detrimental to her health, development and well-being.

D. Women's Health

The health of mothers and children is highly dependant on the status of women. The present situation in Cameroon, especially in rural areas where women have a heavy burden of domestic duties, work in the fields and are prone to numerous offsprings at short intervals, is not favorable to the improvement of the health of women. Maternal mortality is very high, as is morbidity, especially malaria, goiter and complications of pregnancy, delivery and sterility, all of which are exacerbated by the prevailing pro-natalist attitudes, especially of men. (UNFPA)

Maternal mortality is high and estimated at 420 per 100,000 live births. According to studies based on maternity and hospital statistics, hemorrhages (44%) are the main cause of maternal mortality, followed by "medical complications" (15%) and infections (12%). Over 59% of the deaths occurred among multiparity women. (UNFPA)

Abortion is also a cause of maternal mortality. Since abortion is a criminal offense in Cameroon, it is not always reported as abortion. In the provincial hospital in Bamenda, staff report that 31.5% of the maternal deaths there in 1990 were caused by provoked abortions. In fact, of the 9 maternal deaths that occurred there so far in 1991, all but 1 (88.8%) were caused by provoked abortions. The abortions were induced not only by girls, but by widows, women over 40, housewives who already had several children, etc. At the Maternite Central in Yaounde, abortions represented 40% of emergencies in 1988. A private practitioner estimates that there are 60 to 100,000 abortions nationwide each year. This cannot be confirmed because clinics and hospitals do not see cases where the abortions succeed. They only see the ones that went wrong. This alarming fact represents a desperate demand by women for contraception.

Abortions are induced in a number of ways, almost all of which can be very dangerous to the mother. Abortions are usually done by the pregnant woman herself or by a friend, a traditional healer or midwife. High doses of chloroquine, introduction into the vagina of caustic substances and sharp or crude instruments are the usual methods of self-induced abortion.

High risk factors are found in 27% of all pregnant women. The national nutrition survey conducted in 1978 found that women are not in good health. They are chronically undernourished, lack energy reserves, have anemia and maybe also goiter due to malnutrition and iodine deficiencies. They are prone to malaria, worms, venereal diseases and skin diseases.

57% of all women give birth in a health clinic, maternity or hospital (UNICEF, 1990). There are 600 trained traditional midwives or birth attendants in Cameroon. 96.9% of all women who deliver at home do so with the assistance of a traditional midwife or a family member. Even in Yaounde in 1978, 16% of all deliveries were at home (UNICEF, 1990).

E. Children

Children under five years of age represent 18.4% of the population (UNICEF). Children are considered by parents and the larger social group to be the center of the family, the reason for having a family, the replacement for the parents and the continuation of the lineage. Parents also consider

children important because they believe their children will care for them in their old age; they are gifts from God, the happiness of their parents.

Infant mortality is estimated to have declined from 116 per thousand in 1978 to 88 per thousand at present (UNICEF, 1990). It is still responsible for 30% of the deaths in the country. The state of women's health, i.e., malnutrition, is responsible for low birth weight of 11% of all children (under 2.5 kg) and their general weakness and susceptibility to diseases later in childhood (UNICEF, 1990).

The National Fertility Survey (1978) found that 15% of infant mortality was due to pregnancies which were two years or less apart (UNICEF). In other words, if those births were spaced at least two years apart, all other things being equal, there would be a 15% reduction in infant mortality.

F. Social communication and traditional opinion leaders

Traditionally, social communication is between and among men, or between men and spirits or ancestors. As in most of Africa, traditional opinion leaders are men: village headmen or chiefs, notables, elders, religious leaders, healers, griots, etc., depending on which ethnic group is concerned.

Social communication where the whole village is involved might be more of a cultural nature: performances of songs, theatre, poetry, dances. For women, social communication means interaction with other women. The design team saw one project where the status of women had been improved over the years to the point where women could speak in front of the whole village.

A woman is usually expected to submit to the opinion or decision the men make about her or her children. In any society in Cameroon, men are at the core of decisions about a family's reproduction. Older men especially have a very conservative attitude about childbearing. They tend to block their wives' access to family planning out of jealousy. It is generally taboo for women and their husbands to discuss sex. Family size and child spacing decisions are the husbands', although younger men are beginning to think that married couples should share these decisions. For Cameroonian women, biology is destiny.

Some clinics which have been providing family planning services for some time contend that the women are entirely convinced of the need to child spacing, and the men are reticent only out of ignorance. These service providers insist that men are and will be convinced if time is taken with them to lay out all the arguments for family planning. As a result, the IEC component will target men opinion leaders and role models.

G. Impact of Westernization and Urbanization on traditional values and practices

In another ten years, over half of all Cameroonians will be living in urban areas (cities with 100,000 inhabitants). With urbanization, there is generally a breakdown or an adaptation of traditional values and practices. Part of this is because of the influence of westernization, much more evident in the cities, and part of it is from people being forced to adapt the values and practices they have to the new situations with which they are presented in the cities.

People in search of employment or trade migrate to cities, bringing with them their value system, beliefs and practices which served them well in the rural areas because they were adapted over centuries by a fairly static population. Once in the cities, they find that other values, beliefs and practices exist and that reinforcement of their own is lax or non-existent. Over short periods of time, they begin to adapt theirs to suit their new needs. Thus, the traditional ideas about large families being a good thing are gradually being eroded by the realities of living in a city. Family planning acceptance is up to 15% in Yaounde and Douala, as compared to less than 3% nationwide (UNFPA,

April, 1991). However, in cities the traditional practice of the new mother going back to her family for long periods of time after delivery is often difficult and too expensive to permit, so abstinence is shorter, which means that pregnancies are closer together. Whereas in rural areas, when one child was weaned and sent to live with his grandmother or aunt because the mother was again pregnant, a child in the city is more likely to stay in his nuclear family, and burden his mother.

Once adequate and sufficient facilities are available, contraceptive practice is expected to increase very rapidly, especially in the cities. The public sector of this project focusses on integrating family planning through the primary health care system, which will be essentially functional in rural areas. The private, confessional and parastatal sector activities of this project will assist clinics in urban areas.

H. Women's Access to Information

Women have access to information and news from several sources: their friends, relatives, husbands; the media; meetings or groupings, such as those at health clinics; and to a limited extent, the work environment.

Information about family planning methods is often passed by friends and relatives of women, sometimes with glaring inaccuracies. Often it is only rumor. The media is accessible to only a few women: all television and radio programs are in either French or English which less than 50% of women understand if they are free to watch or listen. No effort is made on the part of the media to cover topics of interest to women, especially rural women, development issues or family planning.

The health centers, hospitals, PMIs and rural health posts including the traditional midwives will be the principal sources of information about child spacing and family planning for most women. The workplace, for the small proportion (3% of all active women) of women who have salaried positions could also be a good source of information.

VI. Potential for Family Planning Acceptance

This project will use the following strategies to help the GOC to increase acceptance of family planning methods.

A. Child Spacing/Mother and Child Health

The most compelling reason for supporting family planning in Cameroon is for the health of the mother and her children. We have seen the figures that argue for family planning for women who are not in good health, have already had a number of children, are over 35 and under 18 years of age and are otherwise at risk. This project will use the mother and child health strategy to promote family planning through spacing children. Spacing children will be recommended to allow the mother sufficient time to recover from the birth of one child before getting pregnant again. She will be able to build up bodily reserves which are depleted during pregnancy and delivery. It will also give the newborn a better chance of survival, longer time at his mother's breast, thus better nutrition and more attention from his mother and family.

B. Parente Responsable - Right to Choose

The argument for responsible parenthood is the an important element of the forthcoming national population policy. The reasoning is that parents plan for only those children for whom they will be able to properly care, nourish, educate, etc. Responsible parenthood also espouses the idea of the right to choose when and how many children to have.

C. Infertility

Proper attention to this serious problem is necessary for this family planning program to succeed. In Cameroon, where 26% of the women are infertile, much credibility can be gained through adequate attention and treatment for infertility.

D. Economic Crisis

The rising costs of housing, food, clothing, schooling coupled with increasing unemployment and political and economic uncertainties in Cameroon may be the most convincing reason for many people to practice family planning.

VII. Possible Social Constraints to the Project

A. Men's Attitudes/Tradition

This will be the most important constraint the project will have to address. Men's traditional roles as head of families and the principal decisionmakers in Cameroonian society mean that any child spacing activity will have to convince them of its advantages. Men and the traditional hierarchy will have to see clearly the advantages of child spacing for them, personally and as a group. We have already seen that child spacing for the health of his wife or child is not necessarily the argument to use with a man who believes that a woman's role is to have his children, support and obey her husband blindly and care for him and his children.

In some rural areas where the population is very dense and in the urban areas where not only demographic pressures but also economic and social ones burden families, men have shown themselves to be more amenable to spacing children and principles of responsible parenthood. Younger men, whether influenced by western ideas or economic realities, are also more likely to accept family planning.

The traditional role of women in society will continue to be a serious constraint to project success.

B. Religious

The two religious groups which historically have been constraints to increasing the use of family planning are the Catholics and the Muslims. Catholics are specifically against any artificial method of family planning. They see children as given by God and a couple does not have the right to tamper with God's work.

Religious constraints relating to Islam have more to do with sociological criteria than with actual religious beliefs. The low status of women, the lower rates of education, earlier ages of marriage, higher chances of being in a polygamous relationship are typically found in Muslim societies. Muslim men are generally the providers for their families, and proud of this. With a sensitive and consistent IEC campaign aimed at this group, this constraint could be reduced.

C. Political/Legal

Although the President has publically come out in favor of responsible parenthood, many of the other political and administrative leaders haven't moved as fast and are still living in the days of President Ahidjo's pro-natalist regime. A SEATS training on minilaparotomy was almost canceled by the MOPH during project design. No apparent reason, other than "uneasiness" at people's reactions was advanced.

D. Uneasiness of service providers to provide Family Planning to unmarried Women.

Although there is no official text which says that only married women could obtain family planning services, providers seemed reluctant to serve unmarried women or girls. Many would admit they sometimes would if the girl was brought in by her parents, if it was clear that the girl was already sexually active, i.e., she already had children, or if she had reached a certain age. More providers, especially in the confessional sector, were concerned about having a reputation of encouraging sexual promiscuity or even prostitution if they provided family planning services to anyone who asked.

This uneasiness must be addressed by the project. It should be addressed through training that service providers and counsellors will receive so that they know who can receive family planning services.

E. Lack of Male Outreach Workers

Most of the MOPH and MINASCOF outreach workers are women, whereas the decisionmakers in the family are men. The IEC component of this project will have to devise strategies specifically to reach men. This may be by contacting them at their places of work, through their tontines or mutual support groups, at village meetings, through their drinking places or any other means.

F. Prevailing Rumors about Family Planning

In 1990 during the Expanded Program of Immunization (EPI) launched by the MOH, rumors spread that tetanus vaccinations for schoolgirls were actually sterilizing the girls. These rumors caused parents to withdraw their girls from schools during the campaigns, first in one province, then in another. The rumors were spread by people who claimed that the "sterilization" campaign was aimed at certain ethnic groups. This misinformation not only destroyed the vaccination campaign that year, but heightened acute ethnic rivalries.

Other rumors and misinformation about family planning methods are widespread. Some examples are: modern methods of contraception may cause serious side effects, the Pill can cause sterility, bleeding, multiple births and can damage the female organs. Some men are concerned about the safety of condoms and believe they can wound the penis or cause cancer.

Coordination of family planning IEC with other activities and full and timely information in communities is the way to address these before they become issues. If and when rumors do spread, they must be immediately and fully countered with the truth.

G. Informal Practice of Requiring Husband's/Parent's Consent

Some service providers require that couples present themselves for family planning and will not serve a woman alone. This practice is informal and found more often in the religious and public sectors than in the others. This practice tends to leave sexually active girls and women who are not married or whose parents are not aware of their activity without protection against pregnancy. It also tends to reinforce colonial western values of sexuality and premarital sex which sometimes run directly counter to cultural values.

H. Incentive Payments

The Cameroon civil service compensation plan includes payments of approximately 1800 FCFA (USD 6) for each child of an employee up to a limit of six children. There are in excess of 200,000 civil servants in the country eligible for these payments. Most of these are relatively well paid bureaucrats in urban areas. It is unknown to what extent these incentive payments encourage large family sizes.

USAID plans to request the Population Council, an A.I.D. centrally-funded cooperating agency, to research this question. In any case, given reductions in civil servant salaries and benefits, it is possible that this payment will be reduced or eliminated in the near future.

VIII. Beneficiaries

In this project there will be three types of beneficiaries: individuals receiving services they would otherwise not receive, individuals providing services and organization receiving assistance. In general, all Cameroonians in the four target provinces will benefit from increased and improved access to child spacing information and services, and, by taking advantage of this access, will be better off economically and sociologically.

About 1,135,000 million women and 1,800,000 children (UNICEF, 1990) who will have access to the services strengthened and provided under this project in the four target provinces will be direct beneficiaries.

A. Individuals

1. Women of reproductive age receiving family planning services, pre- and post-partum care and other maternal health services will be the primary beneficiaries of this project. A project goal is to increase the contraceptive prevalence from an estimated 2% to 7% of married couples. An estimated 1.309 million women of reproductive age in 1997 in the four provinces will mean that about 91,630 women and their partners will benefit. Improved health care will help decrease maternal mortality and identify potential family planning acceptors. An additional 500 women will benefit from the research to be conducted on Norplant.
2. Women who are infected with sexually transmitted diseases and those who are infertile will benefit from this project through better STD detection and the availability of drugs for treatment. This means that an estimated 26% of Cameroonian women in the four provinces (approximately 340,000 in 1997) who suffer from infertility could be helped, since venereal diseases account for the great majority of cases of infertility. Earlier detection and treatment of STDs will have a direct impact on the infertility rates in the country.
3. Children will benefit from this project by being better spaced within the family, thus having a greater chance of survival.
4. Men and other individuals will benefit from this project by becoming more aware of child spacing, the advantages it offers to plan for children and the role it plays in the health of the mother and children. Again, it is difficult to estimate the numbers of people who may be sensitized through IEC.

B. Service Providers

1. Doctors, nurses and midwives who will receive training in the private, public, parastatal and confessional sectors to provide family planning services, including information, education and communication services. An estimated 1400 service providers in the four target provinces will receive training.
2. Twenty laboratory technicians who will be working in the target health centers will receive training in STD detection. Six doctors who will be conducting the Norplant trials will receive training in this medical research methodology and procedures.
3. An estimated 100 trainers from all sectors will be trained by the project as trainers or to enhance their training skills.

C. Organizational

1. FEMEC

FEMEC will benefit from this project by enhancing its skills in developing project proposals for donor support. Its member church groups and some 20 hospitals and up to 60 satellite clinics will benefit by being able to provide full child spacing services to its clients.

2. Parastatals

Over 15 parastatal companies will benefit from this project by offering to their employees a full package of child spacing/maternal health services. Over time, the companies will spend less money on health care, and will have more productive employees, in part because there will be less absenteeism for health reasons. This will benefit the companies' profitability over the long run.

3. Private clinics

About 20 large for-profit private clinics will benefit from the project by being in a better position to provide child spacing services because of the training, IEC materials, standards to guide them and commodities they will receive. They will potentially generate more business for themselves by publicizing their services.

4. Commercial interests to benefit from this project will include designers and printers of IEC material, the private press, advertising agencies and local research organizations.

5. CUSS and CESSI will benefit from this project by being in a position to provide higher quality education to the nation's graduating doctors and nurses. At least ten faculty members will be trained to teach the new curricula being developed around reproductive health. These two schools will also have models and other audio-visual equipment as teaching aides.

6. The MOPH as a whole and the DFMH especially will be strengthened in the areas of strategic planning for child spacing, coordination and management. It will also have improved capabilities in financial management, family planning information management, IEC support and supervision and evaluation. It will benefit from the DPRM's new reorientation of PHC by having better access to a larger population at the health centers.

The DPRM will benefit from the DFMH's increased capabilities to provide technical support for child spacing in the implementation of the reorientation of the PHC.

IX. Participation/Impact

A. Participation

Participation in the project design has been achieved with the MOH, both at the central level and at the various decentralized levels. The design team met with responsible parties from the DFMH, DPRM and the minister's office on several occasions and draft papers were distributed, discussed and modified. On its visits to the field, the team was accompanied by staff from the DFMH.

The project is assured of local participation in decision-making related to it because of the formation of the community health committees taking place under the reorientation of PHC. The community health committees will be responsible for managing the health centers and the drug stores, which

include the integration of a child spacing component. Information, Education and Communication activities will be largely responsible for motivating men and women to become family planning acceptors, many through the channels of local groups, traditional and modern opinion leaders.

B. Impact

Because the reorientation of the PHC is based on community participation and responsibility for its own health, the potential for the extension of project activities beyond PACD is great. The activities in the public sector, if successful, will easily lend themselves to replication, first to the entire populations in the four provinces targeted under this project, and next to the remaining provinces. Any replication will necessarily have to be undertaken in the context and integrated with the reorientation of PHC.

In the private, parastatal and confessional sectors, where health care is already well-organized and quite efficient, replication will be much easier, once the target areas are implementing child spacing activities. The clinics targeted in this project will be models for other clinics in these sectors.

The far-reaching impact of this project is that people will realize that they can exercise more control over their lives.

X. Conclusion: Socio-cultural Feasibility of Project

Several forces in the socio-cultural setting in Cameroon make this project feasible. The economic crisis and rapid urbanization of the population are making family planning more acceptable. The integration of maternal and child health interventions with child spacing recognize necessary links for a healthy family. The overriding concern on the part of the population with fertility and infertility will be addressed by the project, and thereby make family planning more acceptable.

The government will soon adopt a national population policy which will continue to turn the tide of men's pro-natalist thinking, by urging them to be responsible parents. Men, especially opinion leaders, will be target for IEC campaigns in this project.

Evidence here has shown that women, regardless of age and social status, are already expressing a high demand for contraception. By making quality services available in more clinics, public and private, for a reasonable price, and informing people of their availability, more women will have access and use the services.

Based on this understanding of the socio-cultural situation in Cameroon we feel that this project is socially sound.

Annex F
Organigram of the MOPH

Organigram of the MOPH

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ANNEXE 2

MOUVEMENTS DES MEDICAMENTS AU DEPOT PHARMACEUTIQUE

1. APPROVISIONNEMENT REGULIER DU DEPOT EN MEDICAMENTS ET PAPETERIE

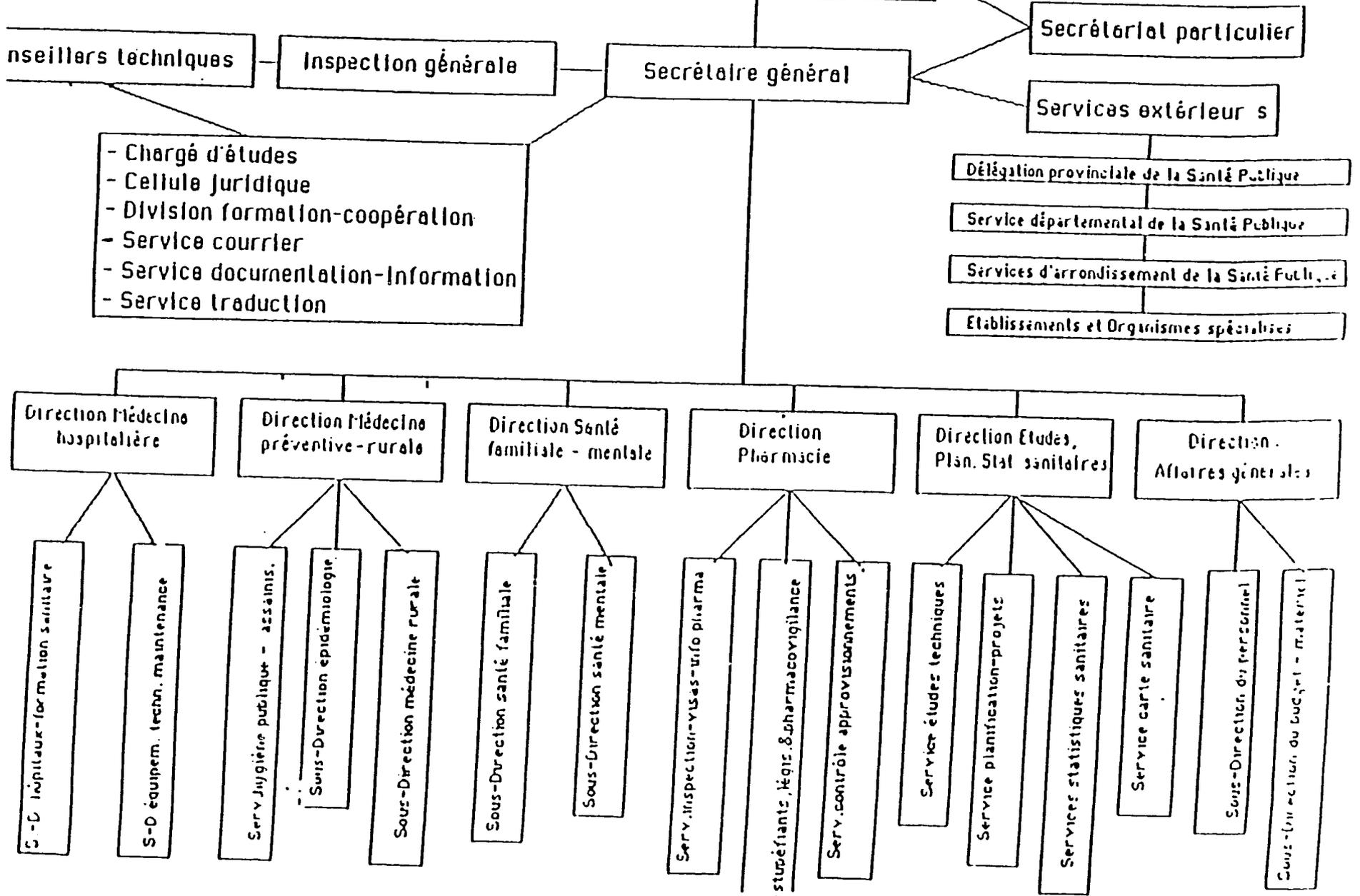
1.1 INTRODUCTION

Les dépôts, généralement situés dans un chef-lieu départemental approvisionnent les hôpitaux et les centres de santé. Les hôpitaux et les centres de santé vendent les médicaments aux patients. Les centres de santé approvisionnent également les cases-santé qui à leur tour vendent les médicaments aux patients.

Les dépôts commandent les médicaments trimestriellement à la province. La province, en fonction des offres transmet les commandes aux fournisseurs les plus appropriés. Les commandes sont emballées au niveau du fournisseur individuellement pour chaque dépôt. Les colis envoyés par les fournisseurs et reçus par la province sont acheminés vers les dépôts. La province n'est donc qu'un lieu de transit pour les colis destinés aux dépôts.

La figure suivante montre le mouvement des commandes (---->) et des médicaments (====>) dans la province.

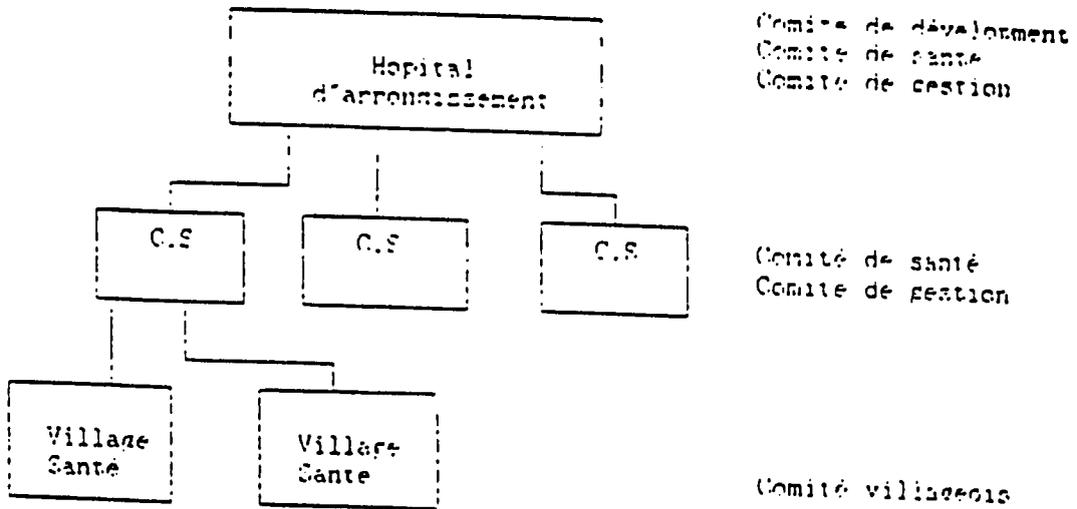
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HEALTH DISTRICT STRUCTURE
INCLUDING HEALTH COMMITTEES



Organigramme structurel d'un district de santé
et structures de dialogues correspondantes.

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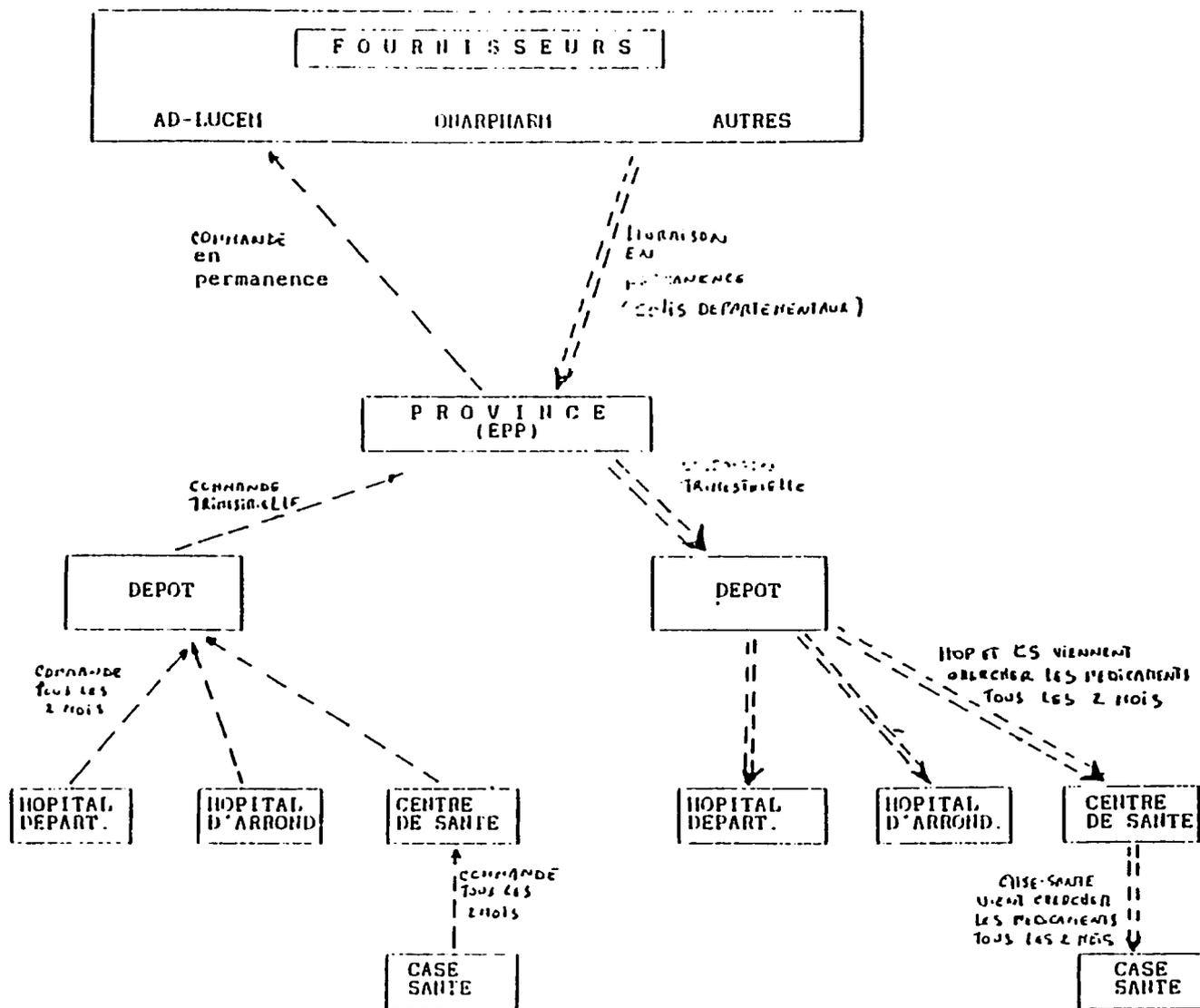
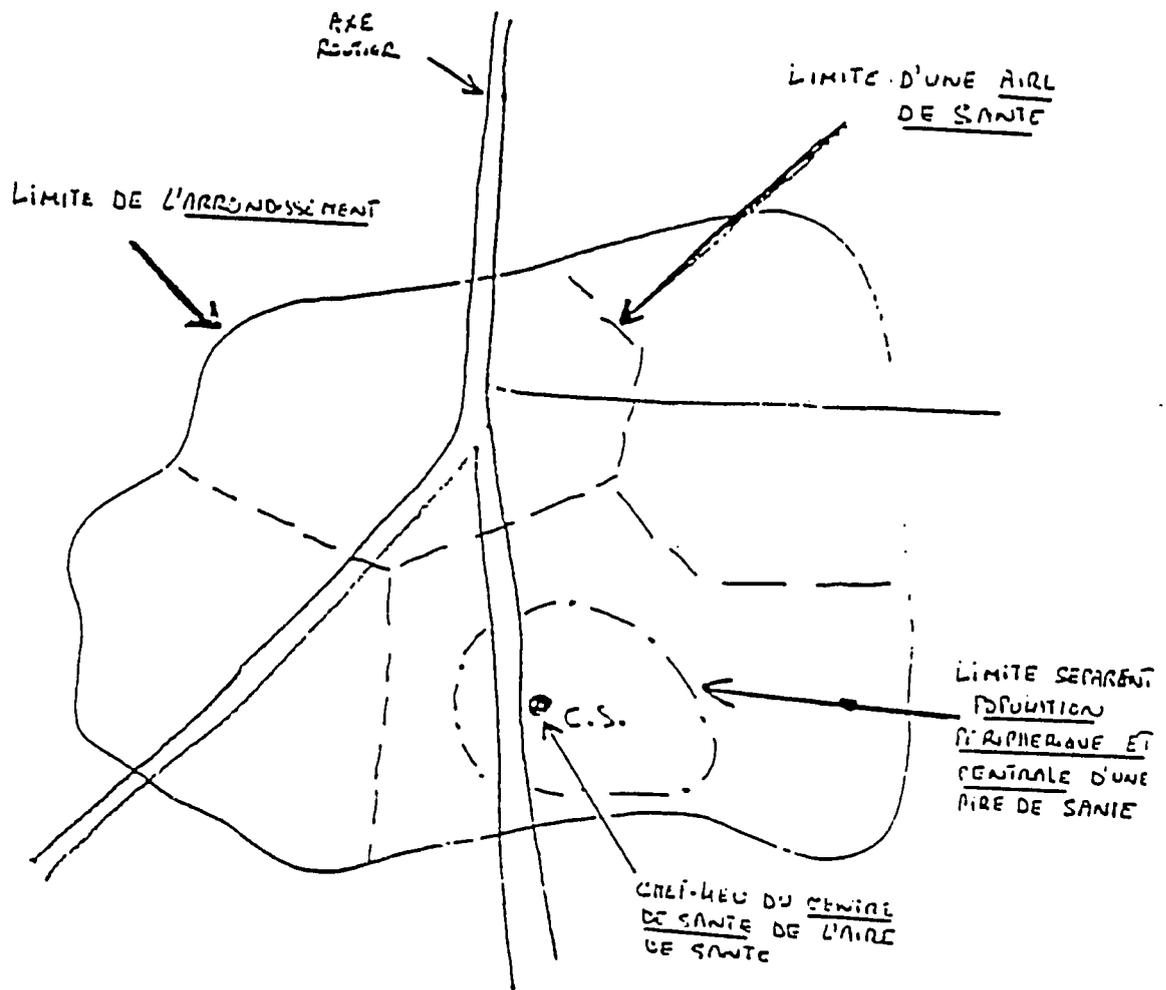


FIG.3 MOUVEMENT DES COMMANDES (---->) ET DES MEDICAMENTS (=====>) DANS LA PROVINCE.

E-1

1991

DIVISION OF A POLITICAL SUBDIVISION (HEALTH DISTRICT)
 INTO HEALTH AREAS



Subdivision d'un arrondissement
 en aire de sante.

Annex G
Procurement Plan Table

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ANNEX I - PROCUREMENT PLAN TABLE

ITEM	SOURCE ORIGIN CODE	SOURCE	SUPPLIER	PROJECT SITE ETA	METHOD OF PROCUREMENT	PROCUREMENT AGENT
Computer/Printer	935	USA, France or Cameroon	Multiple	3 Mo.	Contract	Contractor
Laparoscopes	935	USA	Multiple	3 Mo.	Contract	Contractor
IEC Materials	935	Cameroon	Multiple	3 Mo.		
Radio Campaigns	935	Cameroon	CRTV	Yrs. 2,3,4,5	Contract	Contractor
Radio Serial	935	Cameroon	CRTV	Year 2	Contract	Contractor
Video Production and Duplication	935	Cameroon	Multiple	12 Mo.	Contract	Contractor
Training Materials	935	USA or Cameroon	Multiple	4 Mo.	Contract	Contractor
Contraceptives	000	USA	Multiple	12 Mo. & each year thereafter	PIO/Cs	AID/W
Lab equipment, MCH equipment & MCH drugs	000	USA	Multiple	12 & 24 Mo.	PIO/Cs	USAID/C
Vehicle & Parts	935	Cameroon	Japan	6 Mo.	PIO/C	USAID/C

Procurement Plan Table

Annex C

16/1

Annex H
Training Plan

Annex H

Training Plan

Training will be an important of this project and will be provided for over 1274 public and private sector (including parastatal and confessional) medical personnel engaged in providing maternal health/child spacing services, the majority of whom work at the primary health care level.

I. Pre-Service Training

Pre-service training will take place at the national medical school (CUSS) and at the advanced nursing school, CESSI. Under previous projects, JHPIEGO has already developed four of eight modules for reproductive health curricula for physicians and all four levels of paramedical personnel. With funds already obligated under the Family Health Initiatives II (FHI II) project, remaining modules and the related lesson plans can be completed and training of faculty members from the medical and nursing schools can begin. Development of reproductive health modules with TA from JHPIEGO will be coordinated with the development with TA from INTRAH of standards and protocols for family planning, pre-natal and post-partum care. The pre-service curricula must also be officially accepted by the MOPH to ensure their integration into the schools' medical programs.

Two kinds of training for medical school faculty members will be provided during the life of project by JHPIEGO, which has already received funding under FHI II:

A. Curriculum Development: A two-week follow-up curriculum development workshop for 20 faculty members from the University of Yaounde School of Medicine and the Ministry of Health Schools of Nursing and Midwifery who attended a previous JHPIEGO curriculum development workshop. The workshop will take place at the University facilities and JHPIEGO will provide the technical assistance. The workshop will take place in December, 1991.

The objective of this workshop will be to complete the reproductive health curriculum, with additional modules on STDs, infertility, care of the newborn and gynecology. Following the workshop, the modules will be presented to the MOPH for approval.

B. Faculty Training: A three-week didactic and clinical reproductive health/family planning course (including IUD insertion) for 10 faculty members from nursing schools will be held. Six faculty members will come from CESSI, two from the B-2 nursing school two from the B-1 nursing schools in Yaounde. The training will take place at the University facilities and a clinical practicum will be held at four clinics in Yaounde. The training team will be headed by the JHPIEGO project director and may include other OB/GYN professors from the University, as well as faculty from CESSI and other MOPH trainers. The training is scheduled for May, 1992.

Topics to be covered in the didactic sessions will include:

1. Introduction to population, demographics and the risk factors of maternal mortality;
2. Reproductive anatomy and physiology;
3. Contraceptive methods including breastfeeding and natural family planning;
4. The high risk obstetrical approach and use of the partogram during labor;
5. STD diagnosis and treatment;
6. Screening IUD clients;
7. Administering and managing family planning services;
8. Diagnosis and treatment of infertility;
9. Screening for malignant disease; and
10. Patient counseling and interpersonal skills

Clinical practicums will be organized for IUD insertion and removal. Each participant will be required to insert successfully a minimum of 10 IUDs (Tcu 380A) to be certified competent.

II. In-Service Training

The cooperating agencies will assist in the identification and training of a core group of trainers composed of central MOPH/DFMH personnel and province-based medical who may be chosen from any level within the province. All family planning training in the four provinces will be closely coordinated not only with the DFMH National Family Health program but also with the activities of the donor agencies active in these provinces. All family planning training for the public sector will follow the DPRM PHC training strategy and schedule. The core group of trainers will train the departmental and sub-divisional level service providers, and the latter, in turn, will train health center staff.

Trainers from the private, parastatal and the religious sectors will likewise provide training for health personnel in those sectors.

A. JHPIEGO

1. Detection of Sexually Transmitted Diseases: Approximately 20 lab technicians in the public sector will be trained to detect sexually transmitted diseases. If necessary they will be supplied with microscopes and relevant stains, cultures, slides and other supplies. Two one-week courses, one in the first year and one in the second will be conducted for groups of 10 participants each.

2. Laparoscopy training: JHPIEGO will train six OB/GYNs (two each from the three provincial hospitals) in laparoscopy. The doctors to be trained will be from the high-risk clinics in the hospitals. The training will last five days and will be for using laparoscopes to detect and treat infertility.

3. Norplant Trials: As part of a research grant under the project, JHPIEGO, with its implementing agency CUSS, will be responsible for initiating medical research in Norplant in conjunction with medical personnel at approximately three central-level hospitals in Cameroon. The research will be to study acceptability and the effects of Norplant on Cameroonian women and will involve about 500 women of reproductive age. Under the grant, JHPIEGO may train doctors, but this training will not be counted for purposes of the project training plan. Topics to be covered during the initial training, which will take place during the first year of the project include research methodology, Norplant insertion and removal and client monitoring. During year three, the same participants will receive follow-up training in removing the implants and reporting of trial results.

B. INTRAH

1. Training of Trainers (TOT): In the first year of the project, two 3-week training of trainers courses will be conducted for participants from the central level, the four project provinces and other selected medical personnel from departmental or sub-divisional levels. Ten trainers will be trained at each course and will subsequently comprise the provincial training teams. They will be trained in contraceptive methods, reproductive health, genital tract infections, as well as in other maternal and child health subjects including training for IUD insertions. In year three, 10 more people will receive TOT, for a total of 30 people over the life of project. INTRAH will identify appropriate in-country training sites for clinical practicums which will include IUD insertion.

2. Preceptor Training: This training will involve participants from the provincial, departmental and sub-divisional level hospitals which will be chosen as sites for the family planning practicums. The training will include a five day refresher course in pre-natal and postpartum care, child spacing, care

of the newborn, STDs and infertility treatment. Ten preceptors will be trained in each of two courses in year one and 10 more in year three, for a total of 30 preceptors trained over the life of project.

3. Basic Family Planning/Maternal and Child Health/STDs: This basic course will be conducted for health district service providers by the provincial training teams. INTRAH will field an expert to assist the provincial trainers assigned to deliver the first training session during year one of the project. Each session will accommodate a maximum of 20 participants. Half of the training sessions each year will include an extra week for training in IUD insertion and removal. During the first year, four sessions will be held for 80 people. Two sessions will last three weeks and two will last four weeks and will include the IUD insertion training and practicum. In the second year, four sessions will be held for a total of 80 participants, six the third year for a total of 120 participants, and four during the last two years for a total of 80 participants. A grand total of approximately 360 persons in the four provinces will be trained as MCH/FP service providers over the life of project, and 180 of these will also be trained in IUD insertion and removal.

Topics to be covered during the first three weeks of the basic course are summarized below:

- a. Childspacing: Male and female reproductive systems; contraceptive methods and advantages and disadvantages of each; counselling in method choice; and, dealing with method-related problems.
- b. Antenatal Care: Identification of high risk patients; calculation of delivery date; complete physical examination; health and nutrition education; and management of antenatal services.
- c. Intrapartum Care: assessment of labor progress; identification of abnormalities and need for referral to next health level; preparation for and conducting safe delivery; evaluation of infant's state at birth (AGPAR); and management of the delivery room.
- d. Postpartum Care: prevention of postpartum pathologies; provision of health education for mother upon discharge; importance of 6 week post partum examination.
- e. Care for the Newborn and Children: advantages of breastfeeding; infant and child vaccination schedules; bathing and clothing; care of the umbilical cord.
- f. STDs and HIV/AIDS: Identification of different cases; appropriate treatment and client counselling.
- g. Infertility: Causes, counselling and treatments

4. Maternal Health/Child spacing update with IUD Insertion: During the first week of this training many of the topics listed above will be reviewed while weeks two and three will be devoted to IUD insertion and removal. This update training will target those nurses and doctors who have had the basic course without the IUD practicum. The practicum will take place at sites under the supervision of trained preceptors. Usually, to be certified for IUD insertion, a person must have inserted successfully at least 10 IUDs. In the event that any participant is not certifiable by the end of the course, provision will be made for subsequent supervised practice at the participant's clinic or hospital. Beginning in the second year of the project, two courses with a maximum of 12 participants each (total 24) will be held. In year three, three courses for 36 participants will be given, and in the last two years of the project, four courses for 48 participants will be given. During the life of project, 84 people will receive this training.

5. Update without IUD insertion: Two weeks of training to update participants in MCH/FP will be given three times in year three and five times in years four and five. A maximum of 20 participants will attend each training course, for a total of 160. The content will be drawn from that described

above and will include innovations and results of recent worldwide experiences and studies in maternal health issues.

C. PCS

PCS will provide all training of trainers in information, education and communication for the public sector and will offer a sensitization seminar for national journalists, including those from the private press.

1. IEC training will begin in year 1 with a four-week training of trainers (TOT) and practicum for designated DFMH Central-level Health Education staff and ten provincial level health educators (approximately 15 people). Training will cover: IEC needs assessments, strategic planning, research, message and materials development, program management and evaluation.

The IEC trainers will also work with PCS to prepare training modules to be used for training service providers, social workers and extension agents.

In year three, a two-week TOT will be conducted for all provincial level health educators and some central staff.

In coordination with the MOPH and donor agencies in the four provinces, provincial-level service providers will be trained in FP/IEC by provincial trainers. District level health and other workers constitute another group targeted for FP/IEC training. Training of front-line service providers in IEC for Family Planning will be in conjunction with other training being held and will be a three-day add-on.

For the religious, private and parastatal sectors, training will be coordinated by SEATS. In these sectors three days of IEC training may be added to the clinical training programs described earlier.

2. In year two, ten journalists from the public and private sectors will be invited to a family planning sensitization seminar of about one week. They will be introduced to the concepts of family planning, including how to approach issues in the mass media.

D. SEATS

1. TOT: SEATS will identify a group of about 10 potential trainers from among the private, religious and parastatal sectors. These persons will attend a two week TOT course in clinical FP/MCH services. The trainers to be selected must be active service providers. The two-week course will include refresher training in family planning, including IUD insertion and removal, and adult training methods. The course will be given again in the second year of the project for another group of 10 individuals.

Clinical Training for service providers: SEATS will provide clinical training for the religious, private and parastatal child spacing personnel. SEATS will use local trainers and will work with them to train two service providers from each of the approximately 145 private facilities targeted by the project. The SEATS clinical training will use the Basic Family Planning/MCH modules developed by INTRAH. However, all SEATS clinical training will include IUD insertion and removal and the training will last for three weeks with a maximum of 10 people at each training. It is expected that SEATS will train 40 people in the first year, 80 in the second, 100 in the third and 70 in the last two years for a total of 290 persons trained.

2. Minilaparotomy Training for Physicians: SEATS will provide training in minilap for both public and the private sectors physicians. All doctors will be required to attend with their nurses. Each

training course will last eight days and will accommodate 7 doctors and their 7 nurses. The first two and one-half days will be spent on theory for both doctors and nurses together. For the rest of the course the doctors will practice the minilap procedure while the nurses will be trained in patient counselling.

For the public sector, one course will be held each year over LOP for a total of 35 doctors. For the private sector, two courses per year will be scheduled to train a total 70 doctors. Thus, 105 doctors will be trained in minilap by the end of project.

E. Reform Program Component

Under the component for policy reform, as the PHC with its full repertoire including the child spacing component expands to ten additional districts in the Extreme North province, more people will be trained. The design anticipates that as many as 400 more service providers at all levels of the health care system, but especially at the PHC level, will be trained in reorientation concepts.

Annex I

Initial Environmental Assessment

Annex I

Initial Environmental Assessment

H. Recommended Environmental Threshold Decision

Project Country: Cameroon
Project Title: Family Health Support Project (631-0084)
Funding: OFA FYs 92 - 96 US\$ 7.55 Million

Environmental Action Recommended:
Categorical Exclusion

Summary of Findings

A categorical exclusion of A.I.D. Environmental procedures is recommended on the basis that this project consists of "programs involving nutrition, health care or population and family planning services," under 22 CFR Part 216.2 (c) (viii) of A.I.D.'s Environmental Procedures (A.I.D. HB 1 Appendix 1D). The project does not anticipate any activities "directly affecting the environment (such as construction of facilities, water supply system, waste water treatment, etc.)." Limited funding (about \$100 Thousand) will be made available for renovation of existing facilities.

Clearance:

Mission Director: [Signature] DATE 1/15/91

Concurrence:

Bureau Environmental Officer: APPROVED: _____
DISAPPROVED: _____
DATE: _____

I. A.I.D. Policy Issues

1. Will the delivery of child spacing services on a cost recovery basis make these services less accessible or act as a disincentive to the rural population?

The results of a pilot FHO cost recovery program in Extrême Nord province USAID's experience under the MCH/CS project indicate that people are willing to pay for quality health services. In fact, experience has shown that cost recovery mechanisms, by ensuring the steady flow of essential pharmaceuticals and contraceptives, will increase utilization of health services. The health care expenditure and equity study presently being conducted under the MCH/CS Project will indicate if community health communities need to develop policies for handling indigent persons.

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Annex J
Detailed Description of IEC Component

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Annex J

Detailed Description of IEC Component

IEC in support of child spacing and maternal health in Cameroon has been sporadic and limited in its scope. Previous USAID assistance in this field was initiated in 1988 with a JHU/PCS project whose primary activities were institution building, materials development and qualitative research. A family planning drama was also developed. These ongoing activities will continue and expand under the new project to include both public and private sectors.

The objectives of the IEC component of the Project are:

- to assist the Department of Family and Mental Health (DFMH) to assume a leadership role in coordinating integration of maternal health and child spacing IEC activities into the PHC structure.

- to improve the quality of child spacing and maternal health counseling and interpersonal communication in both public and private sectors.

- to increase overall awareness of child spacing and contraceptive methods by 50 percent among men and women of reproductive age in the project service areas.

- to increase demand for child spacing and maternal health services at project service sites.

The revised PHC program will have a unified IEC strategy incorporating child spacing and maternal health and will plan overall IEC activities to assure that all components are consistent with the unified strategy. This will require specially close coordination between the DFMH and DRPM and between the cooperating agencies working on this project and the contractor for the MCH/CS project.

The principal IEC activities of the project are:

- in partnership with the DRPM, to hold two training courses for a cadre of national and provincial level trainers familiar with child spacing/maternal health counseling and interpersonal communication methodologies and strategies who will serve as trainers for other health workers.

- in partnership with the DPRM, to hold two training courses for a cadre of national and provincial IEC trainers familiar with persuasion strategies, pedagogy, qualitative research, message development, materials development and evaluation, who can train field extension workers to act as motivators and monitor communication impact.

- in cooperation with the SEATS project to hold one IEC training program in improved counseling techniques and interpersonal communication for selected para-public and confessional agencies.

- development of training protocols to be used in IEC counseling training programs for service providers in public and private sectors.

- production of IEC clinic-based materials for use by service providers and for distribution to clinic clientele.

- production of community-based motivational and promotional materials for use by extension workers.

- production of mass media materials for raising awareness and creating a positive climate for child spacing/maternal health among the general population.

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- qualitative research in support of materials development, pre and post testing of materials and evaluation of IEC impact on populations in the catchment areas.

Expected outputs for the project are the following:

1. 40 trained IEC trainers from the four provinces and 20 from selected private sector institutions. Two training sessions of four weeks duration each will be held over the life of the project for the public sector and one for the private sector.
2. Training protocols and materials for service providers prepared and produced for use in service provider training and for in-service use by health workers in client counseling and group lectures. Specifically this will include one flipchart with maternal health/child spacing content and one methods poster.
3. Four posters to be displayed in clinic sites, one counseling against teen pregnancy, one for STD's, one contraceptive methods, one promoting child-spacing. Poster content will be culturally appropriate and may necessitate printing a version for the South, and Central provinces and a different version for the Extreme North and Adamaoua.
4. Motivational material for extension workers consisting of one motivational flip chart on maternal health and child spacing, one audio cassette for male audiences, one on responsible parenthood.
5. Four campaigns in each of the four provinces utilizing provincial radio, one to promote parental responsibility specifically aimed at men, one directing the public to service delivery sites and two others targeted to specific audiences identified by the research.
6. Two fifteen minute video productions, one stressing prenatal health and the other discussing child spacing.
7. Preparation of two reports evaluating IEC impact.
8. National broadcast of a 52 week radio soap opera stressing maternal health and child spacing and parental responsibility themes. One short duration training program will be held for the producers of this series.
9. Prior to development of a child-spacing logo, research will be conducted to determine the need for one, taking into consideration the possibility that PHC will also be developing a logo to promote all five of its interventions including child spacing/maternal health, and that the social marketing program is also considering a (CSM) logo, beyond its brand-name recognition. If a logo is required, a competition will be held in the third year of the project to select an appropriate one and to generate publicity simultaneously.

Implementing agencies and personnel needs:

The Project will provide the technical assistance services of Johns Hopkins University Population Communication Services (JHU/PCS). The DFMH will be the lead implementing agency in Cameroon for the activities specified above. The project director will appoint one staff member of the Health Education Division to work full time on the activities of this project. Additional resource needs to be provided by the DFMH will be a research and evaluation specialist and occasional services of the full Health Education staff to assist with field surveys.

At the provincial level the DFMH will provide the services of the Nutrition education officer to complete the PHC team and assume responsibility for IEC provincial-level activities including assisting with training of health workers, extension workers, distribution of IEC materials, provincial campaigns, IEC research and monitoring and supervision. At the provincial level. JHU/PCS will collaborate with the SESA project assisting them in health worker training activities during the five year life of project. JHU/PCS will prepare

the training protocols for counseling and interpersonal communication during a training of trainers workshop for provincial-level staff. INTRAH and SEATS can include counseling and interpersonal communication in their provincial and private sector clinical training programs for service providers.

Project SESA in South and Adamoua Provinces and Save the Children in Extreme North Province will collaborate with the National Family Health Project on the training of extension workers at the village-level in motivational techniques and advocacy, on training of committee members and on additional targeted training. The protocols and materials for this training will be developed at a training of trainers to be held by JHU/PCS with provincial-and national-level personnel from various Government Ministries providing extension support (e.g. MINASCOF, MINAG, TBA's and VHW's).

The project will hire interviewers for field research activities as needed. Interviewers will be trained in qualitative research techniques by JHU/PCS.

The project will also hire short-term local consultants (10 months over the life of the project) to provide expert assistance as necessary for project implementation. Short-term local consultants will assist with research, training and materials development activities of the IEC component. JHU/PCS will provide 11 person months of expatriate technical assistance to work in training activities, produce materials, plan and implement campaigns, and assist with research, including formative and mid-term evaluations.

JHU/PCS will contract for printing with available printing services including those located in the target provinces. Each of the selected private sector institutions receiving TOT/IEC training will provide one health educator to assist with the coordination of IEC activities and to be the receptor for IEC printed materials. Private sector institutions will receive one free shipment of childspacing/maternal health materials free but will purchase further supplies through HOSPICAM which can coordinate orders and distribution of IEC materials.

A formal request will be made to locate the SESA IEC/Training adviser in the DFMH to facilitate IEC activities under the project. All public sector IEC activities will be closely coordinated with the DRPM in order to respect implementation schedules. All national use of mass media to promote child spacing and maternal health will also be coordinated with the implementation schedule for services delivery and is not expected to begin until year three of the project.

Transportation needs of the IEC activities can be provided through cooperation with Project SESA. The DFMH will assure transportation for technical assistance.